

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03521

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

3520

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>45 Marion St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>E</u> Last <u>Ambrose</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4-1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hancock, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Brady</u>		14. MOTHER'S MAIDEN NAME <u>Susan Craig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>(daughter) Edith A. Heller, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 422.1 DUE TO <u>Chronic myocarditis</u> also had <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arteriosclerosis</u> (b) <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>  </u> <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 9-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 13, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>April 12, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 15 1957  
BUREAU V. S.

3585

## CERTIFICATE OF DEATH

Reg. Dist. No.

J. PLACE OF DEATH  
o. COUNTY

Allegany

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

near Cumberland, rural

c. LENGTH OF STAY IN 1b

years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Xo Cumberland, rural

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

293 National Highway

d. STREET ADDRESS

293 National Highway

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☐3. NAME OF DECEASED  
(Type or print)

John

First

Middle

Last

Reid

Anderson

## 4. DATE OF DEATH

Month

Day

Year

April 26

19 57

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

## 8. DATE OF BIRTH

December 16, 1865 91 yrs.

## 9. AGE (In years last birthday)

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Store Mgr.

11. BIRTHPLACE (State or foreign country)

Bellshill, Lanarkshire

12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

John Anderson

## 14. MOTHER'S MAIDEN NAME

Margaret Reid

Margaret Reid

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT

Address

Wilfred R. Anderson, La Vale, Maryland.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Crown attack  
Hypertension Heart disease  
Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1940 to April 27, 1957, that I last saw the deceased alive on April 26, 1957, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

F. Alan G. Murray, M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type)

F. Alan G. Murray, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/29/57

22c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

April 29, 1957 W.R. Frank, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03524

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN lb <u>60 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>510 Baltimore Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>BARRETT</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u>	
				9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Welder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O.R.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Emma Sellers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes - 1908-1911-Mexican</u>				16. SOCIAL SECURITY NO. <u>420.1</u>		17. INFORMANT <u>Mr. Jerald Barrett, Glencoe, Penna.</u>	
18. CAUSE OF DEATH (Describe one cause only for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>420.1</u> DUE TO <u>Hypertensive cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with coronary insufficiency.</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>902.6 Intertrochanteric fracture of left femur.</u> <u>step and fell to concrete, injured left hip.</u> <u>Coming out of Am. Legion Bldg. in Ridgely W. Va. Missed a</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Am Legion Bldg Ridgely Mineral W. Va.</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>11.30</u> p.m. <u>Dec. 15</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Am Legion Bldg Ridgely Mineral W. Va.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 14-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Silcox Funeral Home, Cumberland, Maryland.</u>				ADDRESS <u>April 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 18 1957

3522

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>J.</b> Last <b>BERKENBAUGH</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 3, 1869</b>	
9. AGE (In years lost, by day) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper Office</b>			
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>LEOPOLD BERKENBAUGH</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ROWAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-6071</b>		17. INFORMANT Address <b>Miss Sadie Berkenbaugh, 50 Wempe Dr.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia - Left</b> <b>490X DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cerebrovascular Disease</b> DUE TO (c) <b>Advanced Age</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? <b>X</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>57</b> , to <b>April</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>April 1</b> , 19 <b>57</b> , and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. O. Himmelwright, M.D.</b>				ADDRESS (Street, city or town, state) <b>133 Virginia Ave, Cumberland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>G. O. Himmelwright, M.D.</b>				DATE SIGNED <b>4/2/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hager Funeral Home</b>				ADDRESS <b>Fruitburg</b>		24. REC'D BY REGISTRAR <b>April 4, 1957</b>	
25. REGISTRAR'S SIGNATURE <b>W.R. Hantz, M.D.</b>				26. REGISTRAR'S SIGNATURE <b>W.R. Hantz, M.D.</b>			

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME		LEOPOLD KERNERMAN	
SEX		MALE	
RACE		WHITE	
DATE OF BIRTH		JANUARY 1, 1895	
PLACE OF BIRTH		POLSKA, POLAND	
OCCUPATION		CONDUCTOR	
DATE OF DEATH		APRIL 1, 1957	
PLACE OF DEATH		BALTIMORE, MD	
CAUSE OF DEATH		CORONARY THROMBOSIS	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
SIGNATURE OF WITNESSES		[Signatures]	

BUREAU V. S.

APR 5 1957

RECEIVED

DR. WEISMAN

3523

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA ROSE</b> Middle <b>BITTNER</b> Last <b>BITTNER</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 12, 1865</b>	
9. AGE (In years last birthday) <b>91</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>1</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Avilton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>NOAH GARLITZ</b>		14. MOTHER'S MAIDEN NAME <b>MC KENZIE, MARTHA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Cerebral Infarction</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>③ Cerebral Arteriosclerosis</b> DUE TO (c) <b>④ Arteriosclerotic Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>#1 instantly</b> <b>#2 1 week</b> <b>#3 5 years</b> <b>#4 unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4/3, 1957</b> , to <b>4/7, 1957</b> , that I last saw the deceased alive on <b>4/3, 1957</b> , and that death occurred at <b>11:22 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Weisman</b>				M.D. <b>59 Green St</b>		DATE SIGNED <b>4/9/57</b>	
PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>				<b>Cumberland, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Robeson Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Durst Funeral Home, Frostburg, Maryland.</b>				24a. REC'D BY REGISTRAR <b>April 10, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Hartz, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN. 15, 1910	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
APR. 11, 1957		BALTIMORE, MARYLAND		11:30 A.M.		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR. 11, 1957		APR. 11, 1957		APR. 11, 1957		APR. 11, 1957	

BUREAU V. 1

APR 11 1957

RECEIVED

## CERTIFICATE OF DEATH

3524

Reg. Dist. No. 4

## INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy ~~may~~ be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>5 DAYS</u>		TOWN <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>SACRED HEART HOSPITAL</u>				<u>109 DECATUR ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CATHERINE</u> (Middle) <u>R.</u> (Last) <u>BOLINGER</u>				(Month) <u>APRIL</u> (Day) <u>24</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>10/29-1881</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>AUGUST HAHNE</u>				<u>Christine Hess</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>DAUGHTER MRS. BOYCE, 109 DECATUR ST.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
17/x IMMEDIATE CAUSE (A) <u>Squamous cell Ca of uterine cervix</u>						<u>12 mos</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Sept. 1956</u>		<u>Extension of Ca into uterus</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-20</u> , 19 <u>57</u> , to <u>4-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-25</u> , 19 <u>57</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Raya W. Bacon</u>				ADDRESS (Street, city, town, state) <u>62 Greene St. Cumberland, Md.</u>			
				DATE SIGNED <u>4-26-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-28-1957</u>		<u>Ros e Hill Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>April 27, 1957</u>		<u>Winter R. Frantz, M.D.</u>		<u>James F. Scarpelli, Cumberland, Md.</u>			

BUREAU V. S.

APR 30 1957

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN lb <b>11 days</b>		d. STREET ADDRESS <b>112 Decatur St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>R</b> Last <b>Bramble</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24-1874</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Freight Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O.R.Ry.</b>	11. BIRTHPLACE (State or foreign country) <b>Folks Mills, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A./</b>		13. FATHER'S NAME <b>John T. Bramble</b>	
14. MOTHER'S MAIDEN NAME <b>Eliza A. Rice</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(wife) Elizabeth Bramble, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>420.0</b> DUE TO <b>Sclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>900.0</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Comminuted intertrochanteric fracture of left femur.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Gradual</b> <b>?</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Fell to the floor.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>6.30</b> o. m. <b>April 21</b> p. m. <b>19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Cumberland, Allegany, Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		DATE SIGNED <b>April 14-1957</b>	
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 16, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc., Cumberland, Maryland.</b>		24a. REC'D BY REGISTRAR <b>April 16, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. R. Frantz, M.D.</b>	

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARJIS AND STATE DIVISION OF HEALTH INFORMATION SYSTEMS

BUREAU V. S.

APR 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03529

3573

## CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. STREET ADDRESS <b>Beachwood Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <b>Ida</b> Middle <b>Bell</b> Last <b>Broadwater</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12, 1876</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Garrett County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Levi Bittinger</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Nobil</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT <b>Charles Broadwater</b> Address <b>Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Essential Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b> DUE TO <b>Arteriosclerosis - Diabetes Mellitus</b> (b) <b>3 mos.</b> (c) <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>MAIN ST</b>	
20f. (City or town) <b>MAIN ST</b>				20g. (County) <b>MAIN ST</b>		20h. (State) <b>MAIN ST</b>	
21. I certify that I attended the deceased from <b>July 16, 1956</b> to <b>April 1, 1957</b> , that I last saw the deceased alive on <b>March 31, 1957</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leslie R. Miles</b>				DATE SIGNED <b>MAIN ST</b>			
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR. M.D.</b>				LOCATION <b>LONA CONING MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>4-4-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Sm Nancy X</b>			



3526

## CERTIFICATE OF DEATH

03530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				d. STREET ADDRESS <b>23 HAMPSHIRE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>BURNS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 30, 1894</b>		9. AGE (In years lost birthday) <b>62</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mem. Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>MONTANA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>GEORGE W. BURNS</b>			
14. MOTHER'S MAIDEN NAME <b>MARY CLARK</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217-10-6712</b>				17. INFORMANT <b>MEMORIAL HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Uraemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis &amp; Decompensation</b> DUE TO <b>18 mos</b> (c) <b>18 mos</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>June</b> , 1955, to <b>Apr 28</b> , 1957, that I last saw the deceased alive on <b>Apr. 28</b> , 1957, and that death occurred at <b>3:48 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay E. Durrett</b>				ADDRESS (Street, city or town, state) <b>236 W. 6th Cumberland</b>			
PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>				DATE SIGNED <b>4/28/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany County</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>May 1, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Outside of

Units

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03531

3586

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD #3 Cumberland Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland, R.F.D. #3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #3 Bedford Rd.</u>				d. STREET ADDRESS <u>Bedford Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Rria</u> Last <u>Burns</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipefitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bro. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Fredrick, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob B. Burns</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Gaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		(If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Willard Ambrose</u> Address <u>R.R. 3 Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Bronchitis &amp; Asthma</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2</u> <u>Chronic Myocarditis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Monday 19 56</u> to <u>April 3, 19 57</u> , that I last saw the deceased alive on <u>April 1, 19 57</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. T. Johnson Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland Md</u>			
DATE SIGNED <u>4-3-57</u>							
PHYSICIAN'S NAME (Type) <u>J. T. Johnson Jr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>				24a. REC'D BY REGISTRAR <u>April 5, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Franky M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JANUARY 5, 1928	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA			
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
APRIL 4, 1968		MEMPHIS		HEART DISEASE		NATURAL	
TIME OF DEATH		HOURS		MINUTES		SECONDS	
10:00 AM		4		15		00	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE	
APRIL 6, 1968		MEMPHIS		JAMES EARL RAY		DECEASED	
SIGNATURE OF REPORTER		DATE OF SIGNATURE		SIGNATURE OF WITNESS		DATE OF SIGNATURE	
JAMES EARL RAY		APRIL 6, 1968		JAMES EARL RAY		APRIL 6, 1968	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03532

3527

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>46 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>		d. STREET ADDRESS <b>1 RT.#5 Cumberland, Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>LARRY</b> Middle <b>ALLEN</b> Last <b>CAGE</b>		4. DATE OF DEATH Month <b>8</b> Day <b>4</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/29/55</b>
9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PAUL F. CAGE</b>		14. MOTHER'S MAIDEN NAME <b>MRS MARY F. RAVENSCROFT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus, acute</b> <b>752X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>since birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>Petechial hemorrhage in stomach, slight hemorrhage adrenal</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 15, 1956</b> , to <b>April 5, 1957</b> , that I last saw the deceased alive on <b>April 5, 1957</b> , and that death occurred at <b>10:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.A. Reiter</b>		ADDRESS (Street, city or town, state) <b>112 Bedford St. Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R.A. REITER</b>		DATE SIGNED <b>April 8, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-8-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cash Valley, Cumberland, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 8, 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03533

## CERTIFICATE OF DEATH

3574

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FROSTBURG</u>		LENGTH OF STAY (in this place) <u>4 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MT. SAVAGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MINERS HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ROSE</u> (First) <u>MARIE</u> (Middle) <u>CARTER</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>APRIL</u> (Day) <u>14</u> (Year) <u>1957</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>SINGLE</u>	<b>8. DATE OF BIRTH</b> <u>SEPT. 17 1956</u>		<b>9. AGE last birthday</b> <u>7 MONTHS 7</u>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MINERS HOSP FROSTBURG MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>FRANCIS CARTER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>VIRGINIA LEE SMITH</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>FRANCIS CARTER, MT. SAVAGE, MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>482X IMMEDIATE CAUSE (A)</b> <u>Dehydration from Intestinal</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 Day</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>"Flu" &amp; Diarrhea &amp; Vomiting</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>2:27</u> <u>APR 14</u>, 19<u>57</u>, to <u>APR 14</u>, 19<u>57</u>, that I last saw the deceased alive on <u>APR 14</u>, 19<u>57</u>, and that death occurred at <u>3:27</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John B. Davis</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Frostburg, Md</u>		<b>DATE SIGNED</b> <u>4/15/57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>APRIL 17 1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>ST. PATRICKS CEMETERY</u>		<b>LOCATION (City, town, or county) (State)</b> <u>MT. SAVAGE MD</u>	
<b>24. REC'D BY REGISTRAR</b> <u>4-16-57</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mr. Nancy H. Rose</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harvey N. Zeigler</u>		<b>ADDRESS</b> <u>Lyndman Pa.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

# CERTIFICATE OF DEATH

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1. NAME, RESIDENCE, HOURS OF DECEASE

2. PLACE OF DEATH

3. SEX, AGE, RACE, COLOR, BIRTH DATE, BIRTH PLACE, MARRIAGE DATE, MARRIAGE PLACE, OCCUPATION, EDUCATION, RELIGION, SOCIAL SECURITY NUMBER, MARITAL STATUS, PREVIOUS MARRIAGES, PREVIOUS DEATHS, PREVIOUS DISEASES, PREVIOUS SURGERIES, PREVIOUS TRAUMAS, PREVIOUS DRUGS, PREVIOUS ALCOHOL, PREVIOUS TOBACCO, PREVIOUS OTHER SUBSTANCES, PREVIOUS OTHER FACTORS, PREVIOUS OTHER COMMENTS

4. CAUSE OF DEATH, MANNER OF DEATH, MEDICAL HISTORY, PRESENT ILLNESS, PRESENT TREATMENT, PRESENT DIAGNOSIS, PRESENT PROGNOSIS, PRESENT COMMENTS

5. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

6. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

7. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

8. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

9. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

10. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

11. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

12. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

13. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

14. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

15. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

16. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

17. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

18. SIGNATURE OF DECEASED, SIGNATURE OF WITNESSES, SIGNATURE OF PHYSICIAN, SIGNATURE OF CORONER, SIGNATURE OF JUDGE, SIGNATURE OF CLERK, SIGNATURE OF OTHER OFFICIALS

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BUREAU V. S.

1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03534

DR. R.J. WILLIAMS

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		d. STREET ADDRESS <b>114 SPRINGDALE STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALTA</b> Middle <b>M.</b> Last <b>CESSNA</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21, 1884</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic in</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM CESSNA</b>		14. MOTHER'S MAIDEN NAME <b>MARY MERCHANT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-9350</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Rheumatic Mitral Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>410X</b> (c) <b>not known</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/8/57</b> , 19 <b>57</b> , to <b>4/4/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/3/57</b> , 19 <b>57</b> , and that death occurred at <b>2:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR. R.J. WILLIAMS</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. R.J. WILLIAMS</b>		DATE SIGNED <b>4/4/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 6, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Maryland.</b>		24. REC'D BY REGISTRAR <b>April 5, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W.R. Frankz, M.D.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03535

3529

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>			d. STREET ADDRESS <b>222 Bell Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Rosetta</b> Last <b>Clise</b>			4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-06</b>	9. AGE (In years lost birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Albert Capel</b>			14. MOTHER'S MAIDEN NAME <b>Beatrice Wright</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-6485</b>		17. INFORMANT <b>Patient's Chart</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416X</b> DUE TO <b>Asbestosis, heart disease &amp; pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fibrosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1953</b> to <b>March 4, 1957</b> , that I last saw the deceased alive on <b>March 4, 1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>B. M. Schindler</b>		ADDRESS (Street, city or town, state) <b>43 Greene Street</b> DATE SIGNED <b>4/1/57</b>			
PHYSICIAN'S NAME (Type) <b>B. M. Schindler M. D.</b>		<b>43 Greene Street</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 7, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>			24a. REC'D BY REGISTRAR <b>April 5, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. R. Frank, M.D.</b>		

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>Robert J. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>1915-10-15</i></p>		<p>4. Place of birth: <i>Chicago, Ill.</i></p>	
<p>5. Date of death: <i>1957-04-08</i></p>		<p>6. Place of death: <i>Chicago, Ill.</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Name of informant: <i>[Signature]</i></p>		<p>12. Address of informant: <i>[Address]</i></p>	

BUREAU V. S.

APR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. While corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03536

3530

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>HAMPSHIRE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREENSPRING 85 X -3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>A.</b> Last <b>COMER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>19 57.</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 28, 1906 51 50</b>		9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT ARNOLD</b>				14. MOTHER'S MAIDEN NAME <b>SARA LLOYD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Autopsy</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operate on August 56 for fibroid (degenerating)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3.24</b> , 19 <b>57</b> , to <b>4.30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4.2</b> , 19 <b>57</b> , and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md</b> DATE SIGNED <b>4-3-57</b>							
ACTUAL SIGNATURE <b>W. F. Williams</b>		M.D. <b>Cumberland, Md</b>					
PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Glen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Greenspring, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Karl Stoffer</b>		ADDRESS <b>Romney, W. Va.</b>		24a. REC'D BY REGISTRAR <b>April 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Kantz, M.D.</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>12 dys.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>ARRETTA</b> Last <b>COOK</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 9, 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Rt. # 3 Cumberland rural</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Bowman</b>		14. MOTHER'S MAIDEN NAME <b>Arretta (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. William C. Cook</b>		Address <b>Rt. # 3 Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Nephritis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1946</b> , 19____, to <b>20 Apr</b> , 19____, that I last saw the deceased alive on <b>20 Apr</b> , 19____, and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Fuller B. Whitworth</b> M.D.		123 Bedford St.,	
PHYSICIAN'S NAME (Type) <b>Fuller B. Whitworth M. D.</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/23/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>April 23, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Hantz, M.D.</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03538

Reg. Dist. No. 8

3587

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Lonaconing</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Crawford</b>				4. DATE OF DEATH Month Day Year <b>April 23 19 57</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1883</b>		
9. AGE (In years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mgr.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Scotland</b> ✓	
13. FATHER'S NAME <b>James Crawford</b>				14. MOTHER'S MAIDEN NAME <b>Christine McConn</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>(sister) Mrs. George Graham, Lonaconing, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>E.U.B. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jenner Cross Roads, Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>4/26/57</b>		
				24b. REGISTRAR'S SIGNATURE <b>Jeanette M. Boul</b>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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3532

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>105 Independence Street</b>		d. STREET ADDRESS <b>105 Independence Street</b>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>MAY</b> Last <b>CUNNINGHAM</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Flintstone, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Ash</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Lashley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Eugene Cunningham</b>		Address <b>107 Independence Street, Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> <b>420.1</b> DUE TO <b>Auricular fibrillation, Coronary Arteriosclerosis,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Myocardial Decompensation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>14 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 1943</b> to <b>April 10, 1957</b> , that I last saw the deceased alive on <b>April 6, 1957</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing St., Cumberland, Md.</b> DATE SIGNED <b>4-11-57</b>			
ACTUAL SIGNATURE <b>Samuel M. Jacobson, M.D., F.A.C.P.</b>			
PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson, M.D., F.A.C.P.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>April 13, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>A. R. Frantz, M.D.</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-20		5. PLACE OF BIRTH Memphis, Tenn.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR OF HAIR Brown		9. COLOR OF EYES Blue		10. COLOR OF SKIN Caucasian	
11. DATE OF DEATH 4-4-68		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH FBI Office, Baltimore		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)		19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF JUDGE (None)	
21. SIGNATURE OF REGISTRAR (None)		22. SIGNATURE OF CLERK (None)		23. SIGNATURE OF ASSISTANT CLERK (None)		24. SIGNATURE OF CHIEF CLERK (None)		25. SIGNATURE OF DIRECTOR (None)	

BUREAU V. S.

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03540

3533

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK AVES.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO CUMBERLAND LA VALE</b> d. STREET ADDRESS <b>RT.#6, Box 182</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>P.</b> Last <b>CURRY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 12, 1935</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>57</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FOY ADAMS CURRY</b>		14. MOTHER'S MAIDEN NAME <b>KATE GRIMM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-50-1687</b>	
17. INFORMANT <b>Foy A. Curry</b>		18. ADDRESS <b>Rt. 6, Box 182 Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>meningitis, acute, meningococci</b> <b>057.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>7 days</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis Liver, duration 2 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>0</b> m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 May</b> , 19 <b>56</b> , to <b>27 Apr.</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>27 Apr.</b> , 19 <b>57</b> , and that death occurred at <b>4:34 P.</b> M., from the causes and on the date stated above. P ADDRESS (Street, city or town, state) <b>W. Alfred Van Ormer</b> DATE SIGNED <b>1225 Center St. 27 Apr. 57</b> ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D. <b>Cumberland, Md.</b> PHYSICIAN'S NAME (Type) <b>W. ALFRED VAN ORMER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4/30/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematorium</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>April 29, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W.R. Frantz, M.D.</b>	



Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. (If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Ralph</b> Last <b>Darrow</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Celanese Worker</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Charles S. Darrow</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Lowdermilk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-05-6309</b>	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> DUE TO <b>2 yrs</b> (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Myocarditis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/16/55</b> , 19____, to <b>4/8/57</b> , 19____, that I last saw the deceased alive on <b>4/8/57</b> , 19____, and that death occurred at <b>9:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.,</b> DATE SIGNED <b>4/9/57</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>4/9/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean, M.D.</b>		Cumberland, Md..	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/11/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>April 11, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>W.L. Frantz, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HOGGARD, JR.		AGE 30		SEX Male		RACE White		DATE OF BIRTH 1/15/1927		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		SPOUSE'S NAME Mary H. Hoggard		SPOUSE'S AGE 28		SPOUSE'S SEX Female		SPOUSE'S RACE White		SPOUSE'S DATE OF BIRTH 1/15/1927	
OCCUPATION Salesman		EDUCATION High School		RELIGION Roman Catholic		MILITARY SERVICE None		DATE OF DEATH 1/15/1957		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		DATE OF DEATH 1/15/1957		PLACE OF DEATH Baltimore, Md.	
SIGNATURE OF PHYSICIAN J. H. Hoggard, Jr.		SIGNATURE OF WITNESSES Mary H. Hoggard		SIGNATURE OF DECEASED James H. Hoggard, Jr.		SIGNATURE OF FUNERAL HOME None		DATE OF DEATH 1/15/1957		PLACE OF DEATH Baltimore, Md.	
SIGNATURE OF REGISTRAR J. H. Hoggard, Jr.		SIGNATURE OF CLERK Mary H. Hoggard		SIGNATURE OF DECEASED James H. Hoggard, Jr.		SIGNATURE OF FUNERAL HOME None		DATE OF DEATH 1/15/1957		PLACE OF DEATH Baltimore, Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3535

CERTIFICATE OF DEATH

Reg. Dist. No.

03542

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>608 VIRGINIA AVE.,</b>	
3. NAME OF DECEASED (Type or print) First <b>CECIL</b> Middle <b>V.</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>1957</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 19, 1910</b>		9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dye House worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celenese Corp</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM L. DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>ELLA VALENTINE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-18-1188</b>		17. INFORMANT <b>Frank Davis</b>		Address <b>Cumberland Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure - ventricular fibrillation</b> <b>414X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic valvulitis and general arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b> <b>unk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Apertion Apr. 11; General malnutrition and mesenteric adenitis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 April</b> , 19 <b>57</b> , to <b>11 April</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11 April</b> , 19 <b>57</b> , and that death occurred at <b>8:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>232 Baltimore Ave</b> DATE SIGNED <b>April 11</b>							
ACTUAL SIGNATURE <b>Carlton Brinsfield</b>		M.D. <b>Cumberland Md</b>					
PHYSICIAN'S NAME (Type) <b>CARLTON BRINSFIELD MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Kight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. DEC'D BY REGISTRAR <b>April 12, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W.R. Kantz, M.D.</b>			

RECEIVED

APR 15 1957

BUREAU V. 3

RECEIVED		APR 15 1957		BUREAU V. 3	
MAYLAND STATE DEPT. OF HEALTH - BALTIMORE 10					
CERTIFICATE OF DEATH					
NAME OF DECEASED					
DATE OF DEATH					
PLACE OF DEATH					
CAUSE OF DEATH					
MANNER OF DEATH					
AGE					
SEX					
RACE					
EDUCATION					
OCCUPATION					
RELIGION					
MARRIAGE					
CHILDREN					
SIBLINGS					
PARENTS					
GRANDPARENTS					
OTHER RELATIVES					
SOCIAL HISTORY					
MEDICAL HISTORY					
SURGICAL HISTORY					
HISTORICAL DATA					
PHYSICAL EXAMINATION					
LABORATORY EXAMINATIONS					
PATHOLOGICAL FINDINGS					
FINAL DIAGNOSIS					
CERTIFICATE NO.					
REGISTERED					

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03543**  
**3588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **4**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>40 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Cumberland (rural)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 476 Valley Road</b>				d. STREET ADDRESS <b>/Box 476 Valley Road.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Calvin</b> Last <b>Dick</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24-1895</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard at the Allegany Ballistic Lab.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Frostburg, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Christian Dick</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hedrick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1 214-07-0304</b>		17. INFORMANT Address <b>(wife) Ruth Hausman Dick, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>  <b>420.1</b> DUE TO <b>Coronary sclerosis</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>about 2 years.</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 20-1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>				24a. REC'D BY REGISTRAR <b>April 22, 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>W.K. Frank, M.D.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**Outside of City Limits**

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

3536

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>122 S. Lee St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Bell</u> Last <u>Early</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31-1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Waites</u>				14. MOTHER'S MAIDEN NAME <u>Mary Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT (daughter) <u>Mary Brown, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>442X</u> DUE TO <u>Cardio-vascular-renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u> <u>2 or 3</u> <u>years.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspections <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 22-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 24, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>April 23, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

Without corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. 8

APR 24 1957

RECEIVED

## 3575 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>WESLEY</b> Last <b>ENGLE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vincent Engle</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Porter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-9804A</b>	
17. INFORMANT <b>Mrs. Wesley Engle, Rt. 3, Frostburg</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular renal</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>disease</b> (c) <b>3-4 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 1956</b> , to <b>4-27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-26</b> , 19 <b>57</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>W. Main St., Frostburg, Md.</b> DATE SIGNED <b>4-30-57</b>			
ACTUAL SIGNATURE <b>H. C. Diehl</b>		M.D. <b>W. Main St., Frostburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>H. C. Diehl, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-30-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>4-30-57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Wm. Stanley H. Ros</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		White		Farmer		Maryland	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
April 15, 1957		10:30 AM		Home		Heart Disease		Natural		J. H. Harris	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF CLERGY		17. SIGNATURE OF CORONER		18. SIGNATURE OF JUDGE	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

RECEIVED  
MAY 2 1957  
BUREAU V. 2

Within corporate limits

3537

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>6/11/54</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				5 B Jane Frasier Village			
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>R.</b> Last <b>Evans</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/23/1881</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Only Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Petersburg, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John Evans</b>				14. MOTHER'S MAIDEN NAME <b>Jane Keplinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-2259</b>		17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> (c) <b>General Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Short-bronchitis obliterans</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Allegany County, Maryland</b>				20g. (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>6/11/57</b> , 19____, to <b>4/29/57</b> , 19____, that I last saw the deceased alive on <b>4/29/57</b> , 19____, and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b> DATE SIGNED <b>4/30/57</b>							
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.				DATE SIGNED <b>4/30/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean, M.D.</b>				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 2, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stallings Cemetery</b>		22d. LOCATION (City or town or county) (State) <b>Near Oldtown Allegany County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>May 1, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <b>Acting D.S.H.O.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1945		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MEMBER OF ARMY		1945		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		CITY OF EDUCATION		STATE OF EDUCATION		COUNTRY OF EDUCATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HIGH SCHOOL		1940		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		CITY OF RELIGION		STATE OF RELIGION		COUNTRY OF RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
METHODIST		1945		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH		STATE OF MANNER OF DEATH		COUNTRY OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
SUICIDE		1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
SIGNATURE OF DECEASED		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES EARL RAY		1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
SIGNATURE OF WITNESS		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES EARL RAY		1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES EARL RAY		1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MAY 1, 1968		MEMPHIS		MEMPHIS	

BUREAU V. 2

MAY 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03547

3576

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOUNT SAVAGE XO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>Box 534</b>	
3. NAME OF DECEASED (Type or print) <b>KATHY ANN GIRL</b> First Middle Last		4. DATE OF DEATH <b>April 24, 19 57</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		9. AGE (In years last birthday) <b>17</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Robert Faidley</b>	
14. MOTHER'S MAIDEN NAME <b>Madlyn Snyder</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>none</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Robt. Faidley, Mt. Savage, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (5 1/2 mos.)</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-24</b> , 19 <b>57</b> , to <b>4-24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-24</b> , 19 <b>57</b> , and that death occurred at <b>11:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H.C. Diehl</b> M.D.		ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>4/25/57</b>	
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>		<b>Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-25-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b> ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>4-25-57</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Wm. Harvey N. Roe</b>	

2061357xVI

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-PATIENTS, 18

DECEASED

MCNEIL SARAH

Box 234

KATHY ANN

BUREAU V. 5

MAY 3 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03548

DR. HIMMELWRIGHT

3538

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>8 DAYS</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				d. STREET ADDRESS <b>202 LAING AVE., CUMBERLAND, MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NINA</b> Middle <b>MAY</b> Last <b>FELTON</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-1905</b>		9. AGE (In years lost birthday) yrs. <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>FRIENDSVILLE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>SAMUEL PRICE FRIEND</b>				14. MOTHER'S MAIDEN NAME <b>MARY JANE ENGLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension-Cardio-vascular Disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b> <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dehydration due to excessive emesis due to Cholecystitis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>April</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>April 7</b> , 19 <b>57</b> , and that death occurred at <b>2:10PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>G. Overton Himmelwright, M.D.</b> <b>4/7/57</b> PHYSICIAN'S NAME (Type) <b>G. Overton Himmelwright, M.D., 133 Virginia Ave., Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc.</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 10, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. L. Frantz, M.D.</b>			





3577

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>39 Bowery St.</b>		d. STREET ADDRESS <b>39 Bowery St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>C.</b> Last <b>FRAM</b>		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-3-1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>self employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Fram</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Preston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-1568</b>	
17. INFORMANT <b>Mrs. Richard Fram, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/28/57</b> , 19 <b>57</b> , to <b>4/28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/28</b> , 19 <b>57</b> , and that death occurred at <b>9:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b> DATE SIGNED <b>4-30-57</b>			
ACTUAL SIGNATURE <b>John C. Devers</b>		M.D. <b>E. Main St., Frostburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John C. Devers, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-1-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Evan. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		24a. REC'D BY REGISTRAR DATE <b>4-30-57</b>	
ADDRESS <b>Frostburg, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Nancy H. Rose</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		ALLEGED	
COUNTY		BALTIMORE	
TOWN		BALTIMORE	
STREET		BALTIMORE	
CITY		BALTIMORE	
STATE		BALTIMORE	
ZIP		BALTIMORE	
DATE		BALTIMORE	
TIME		BALTIMORE	
HOUR		BALTIMORE	
MINUTE		BALTIMORE	
SECOND		BALTIMORE	
DAY		BALTIMORE	
MONTH		BALTIMORE	
YEAR		BALTIMORE	
AGE		BALTIMORE	
SEX		BALTIMORE	
RACE		BALTIMORE	
RELIGION		BALTIMORE	
EDUCATION		BALTIMORE	
OCCUPATION		BALTIMORE	
MARRIAGE		BALTIMORE	
CHILDREN		BALTIMORE	
SIBLINGS		BALTIMORE	
PARENTS		BALTIMORE	
GRANDPARENTS		BALTIMORE	
OTHER RELATIVES		BALTIMORE	
FRIENDS		BALTIMORE	
NEIGHBORS		BALTIMORE	
DOCTOR		BALTIMORE	
NURSE		BALTIMORE	
PHYSICIAN		BALTIMORE	
HOSPITAL		BALTIMORE	
CLINIC		BALTIMORE	
LABORATORY		BALTIMORE	
PHARMACY		BALTIMORE	
STORE		BALTIMORE	
BUSINESS		BALTIMORE	
OFFICE		BALTIMORE	
HOME		BALTIMORE	
OTHER		BALTIMORE	

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1. **INSTRUCTIONS**  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# 3539 CERTIFICATE OF DEATH

03550

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		STATE <u>W.V.A</u>		COUNTY <u>MINERAL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (In this place) <u>17 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RIDGELEY</u>		W.Va. <u>85x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>8 CENTRAL AVE</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>CHARLOTTE</u> (Middle) <u>FRYER</u> (Last) <u>FRYER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 28</u> 19 <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 6, 1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>S. Fuller Barnard</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Barrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Chart</u>		
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
451X IMMEDIATE CAUSE (A) <u>THROMBOSIS OF ANEURYSM OF AORTA</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNCERTAIN</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ANEURYSM OF ASCENDING PART AND ARCH OF AORTA</u> <u>2 years or more</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROSIS &amp; ARTERIOSCLEROTIC HEART DISEASE</u> <u>2 years +</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>MYOCARDIAL INFARCTION - HEMOPERICARDIUM</u> <u>Recent</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 55</u> , to <u>APRIL 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>APRIL 27</u> , 19 <u>57</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stevensman</u>				ADDRESS (Street, city, town, state) <u>59 Greene St Cumberland, Md</u>		DATE SIGNED <u>4/29/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 2, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cem</u>		LOCATION (City, town, or county) <u>Cumberland Md</u>	
24. REC'D BY REGISTRAR <u>April 30, 1957</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>		ADDRESS <u>Cumb Md</u>	



3540

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W.VA.</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY 8.5 X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL &amp; WARWICK AVES.,</b>		d. STREET ADDRESS <b>28 Carpenter Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>TOBIAS</b> Middle <b>Stickley</b> Last <b>GANOE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 12, 1891</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>W.VA. (Hampshire Co.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES GANOE</b>		14. MOTHER'S MAIDEN NAME <b>HARRIETT BOWMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Willard Zirk</b>		Address <b>Ridgeley, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>260 X Diabetes mellitus</b> coteb (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260 X Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-5-54</b> , 19____, to <b>4-3-57</b> , 19____, that I last saw the deceased alive on <b>4-3-57</b> , 19____, and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		ADDRESS (Street, city or town, state) <b>62 Greene St</b>	
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, MD.</b>		DATE SIGNED <b>4-4-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-5-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Ridge Cem.</b>
22d. LOCATION (City, town, or county) <b>Green Ridge, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>April 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Frank M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## 3541 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>12 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>1 Greenspring Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Viola</b> Last <b>Ginevan</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/19/ 1879</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Thomas Runkles</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Bucy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Pt's chart</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-1-57</b> , 19 <b>57</b> , to <b>4-2-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-1-57</b> , 19 <b>57</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. C. Zimmerman</b>		ADDRESS (Street, city or town, state) <b>Cumberland Md.</b> DATE SIGNED <b>4-2-57</b>	
PHYSICIAN'S NAME (Type) <b>C. C. Zimmerman</b>		<b>Old Baltimore Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 4, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oldtown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>April 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Frank, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		Jan 1, 1922	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		April 5, 1957		10:30 AM	
Occupation		Usual Residence		Place of Death		Physician	
Teacher		123 Main St.		Home		Dr. Smith	
Hospital		Funeral Home		Burial Place		Interment	
St. Mary's		Doe & Sons		Catholic Cemetery		Buried	
Physician's Signature		Signature of Informant		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		City		County		State	
April 10, 1957		Baltimore		Baltimore		Maryland	

BUREAU V. S.

APR 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Part 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03553

3512

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>24</u> years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>232 Kraft Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Glover</u> Last <u>Glover</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16-1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>51</u> Days <u>51</u> Hours <u>51</u> Min. <u>51</u>	IF UNDER 24 HRS. Months <u>51</u> Days <u>51</u> Hours <u>51</u> Min. <u>51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storeroom clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O.R.Ry.</u>	
11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chauncey Glover</u>		14. MOTHER'S MAIDEN NAME <u>Alfretta Dodge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-05-4430</u>	
17. INFORMANT (wife) <u>Edith Glover</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of throat with</u> <u>148X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pharyngeal hemorrhage also had</u> DUE TO (c) <u>malnutrition.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 8-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>April 9, 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. K. Frank M.D.</u>	

RECEIVED

RECEIVED



With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03554

3543

CERTIFICATE OF DEATH

Reg. Dist. No.

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>15 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>321 NORTH CENTRE ST.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>CATHERINE</b> Last <b>GOEBEL</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/10/77</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper at</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>JOHN RILEY</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET HOOPENGARDNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT Address <b>Wm. Goebel Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>422.2</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unknown</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/2/57</b> , 19____, to <b>4/25/57</b> , 19____, that I last saw the deceased alive on <b>4/25/57</b> , 19____, and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. J. Williams, M.D.</b>				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>4/25/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 26, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. D. Frantz, M.D.</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JOHN RILEY		45		M		W		1912		NEW YORK		NEW YORK		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1000 BROADWAY		LABORER		HEART DISEASE		NATURAL		1957		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1957		NEW YORK		NEW YORK		NEW YORK		1957		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1957		NEW YORK		NEW YORK		NEW YORK		1957		NEW YORK		NEW YORK		NEW YORK	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3578

## CERTIFICATE OF DEATH

Reg. Dist. No.

03555

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MINERS</u>				d. STREET ADDRESS <u>Centennial St. Ext.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Goldsworthy</u>				4. DATE OF DEATH Month Day Year <u>April 24 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24, 1957</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>21</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Goldsworthy</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Devlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Centennial St. Ext. Richard Goldsworthy Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature birth (7 mos.)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mother had 2+ albumen throughout pregnancy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-24</u> , 19 <u>57</u> , to <u>4-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.C. Diehl</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Frostburg, Md. 4/24/57</u>			
PHYSICIAN'S NAME (Type) <u>H.C. Diehl M.D.</u>				<u>Frostburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Montesano</u>				ADDRESS <u>3 E. Main, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-24-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. Harvey N. Rose</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2061353XV2

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>William J. Thompson</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>64</i></p>		<p>4. DATE OF DEATH <i>April 29, 1957</i></p>	
<p>5. PLACE OF DEATH <i>Home</i></p>		<p>6. CITY <i>Baltimore</i></p>	
<p>7. COUNTY <i>Harford</i></p>		<p>8. STATE <i>Md.</i></p>	
<p>9. OCCUPATION <i>Retired</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>11. MANNER OF DEATH <i>Natural</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>W. J. Thompson</i></p>	
<p>13. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>14. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>15. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>16. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>17. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>18. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>19. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>20. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>21. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>22. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>23. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>24. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>25. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>26. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>27. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>28. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>29. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>30. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>31. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>32. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>33. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>34. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>35. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>36. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>37. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>38. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>39. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>40. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>41. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>42. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>43. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>44. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>45. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>46. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>47. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>48. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>49. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>50. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>51. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>52. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>53. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>54. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>55. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>56. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>57. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>58. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>59. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>60. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>61. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>62. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>63. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>64. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>65. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>66. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>67. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>68. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>69. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>70. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>71. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>72. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>73. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>74. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>75. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>76. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>77. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>78. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>79. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>80. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>81. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>82. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>83. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>84. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>85. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>86. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>87. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>88. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>89. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>90. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>91. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>92. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>93. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>94. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>95. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>96. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>97. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>98. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	
<p>99. SIGNATURE OF DECEASED <i>W. J. Thompson</i></p>		<p>100. SIGNATURE OF WITNESSES <i>W. J. Thompson</i></p>	

BUREAU V. 2

APR 29 1957

RECEIVED

4-24-57 J. J. Murphy

3541

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD</b>				c. LENGTH OF STAY IN 1b <b>2½ HRS.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>				d. STREET ADDRESS <b>1 928 KENT AVE.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>		Middle <b>EDWARD</b>		Last <b>HAST</b>	
4. DATE OF DEATH		Month <b>APRIL</b>		Day <b>12</b>		Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 25, 1913</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Plant</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD HAST</b>				14. MOTHER'S MAIDEN NAME <b>BLANCHE JAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-4352</b>		17. INFORMANT <b>Lillian Hast</b>		Address <b>928 Kent Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-vascular Disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>57</b> , to <b>April</b> , 19 <b>57</b> ; that I last saw the deceased alive on <b>April 12</b> , 19 <b>57</b> , and that death occurred at <b>9:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. _____					
PHYSICIAN'S NAME (Type) <b>O. G. HIMMELWRIGHT</b>		<b>183 Virginia Ave. Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 15, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		M.D. <b>M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		35		M		W		1922		NEW YORK	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		1945		NEW YORK		1967		NEW YORK		HEART DISEASE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANAGER		1950		NEW YORK		1967		NEW YORK		HEART DISEASE	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HIGH SCHOOL		1940		NEW YORK		1967		NEW YORK		HEART DISEASE	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
CATHOLIC		1940		NEW YORK		1967		NEW YORK		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1967		NEW YORK		HEART DISEASE		1967		NEW YORK		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1967		NEW YORK		HEART DISEASE		1967		NEW YORK		HEART DISEASE	

BUREAU V. S.

APR 17 1967

RECEIVED

3579

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>45 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>224 Frostburg, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				d. STREET ADDRESS <b>90 Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>James</b> Last <b>Hawkins</b>				4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27th, 1911</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.		IF UNDER 24 HRS. Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman, Spin. Dept.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Richard Hawkins</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Hanna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-01-8837</b>		17. INFORMANT <b>Mrs. Grace E. Hawkins, Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 3</b> , 19 <b>57</b> , to <b>Apr 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Apr 3</b> , 19 <b>57</b> , and that death occurred at <b>10:40</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>Apr 5 1957</b>							
ACTUAL SIGNATURE <b>Wom Lane MD</b>				PHYSICIAN'S NAME (Type) <b>Wom Lane MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 6th, 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>West Salisbury, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>4-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy H. Roe</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

3545

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN CUMBERLAND

MARYLAND

LENGTH OF STAY  
(in this place)  
35 MIN.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN RURAL ---CUMBERLANDHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

SACRED HEART HOSPITAL

STREET  
ADDRESS

RT# 5, WINCHESTER ROAD

3. NAME OF  
DECEASED  
(Type or Print)

(First)

ADRIAN

(Middle)

MARION

(Last)

HOLT

## 4. DATE (Month)

(Day)

(Year)

OF  
DEATH

APRIL 22, 19 57

## 5. SEX

MALE

6. COLOR OR  
RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

MARRIED

## 8. DATE OF BIRTH

MAY 31, 1909

## 9. AGE last birthday

47 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

SHOVEL OPERATOR

10b. KIND OF BUSINESS  
OR INDUSTRY

CONSTRUCTION

## 11. BIRTHPLACE (State or foreign country)

MARYLAND Corriganville

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME

JOSEPH HOLT

## 14. MOTHER'S MAIDEN NAME

JOSEPHINE Retzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, and, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

214-05-9779

## 17. INFORMANT &amp; ADDRESS

PT'S CHART

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH420.1 IMMEDIATE CAUSE (A) acute coronary occlusion  
ANTECEDENT CAUSE(S) DUE TO  
DISEASES OR CONDITIONS, IF ANY, (B) arteriosclerosis  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST, DUE TO  
(C)

1 hour

1 hour

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

None

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While ☐ Not while ☐  
at work ☐ at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-22, 19 57, to 4-22, 19 57, that I last saw the deceased

alive on 4-22, 19 57, and that death occurred at 4:45 A.M. from the causes and on the date stated above.

## SIGNATURE

W. R. Hines

M.D.

57 Green St. Cumberland, Md.

## ADDRESS (Street, city, town, state)

## DATE SIGNED

4-22-57

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

4/25/57

## NAME OF CEMETERY OR CREMATORY

Sts. Peter &amp; Pauls Cem

## LOCATION (City, town, or county)

Cumberland, Maryland

(State)

## 24. RECEIVED BY REGISTRAR

## REGISTRAR'S SIGNATURE

Walter R. Grant, M.D.

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

John J. Hafer, Cumberland, Maryland

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy of the certificate should be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

NAME: **JOSEPH JOHN**  
AGE: **31**  
SEX: **MALE**  
RACE: **WHITE**  
DATE OF BIRTH: **MAY 31, 1926**  
PLACE OF BIRTH: **CORRIGANVILLE, IOWA**  
RESIDENCE: **214-02-3729**  
OCCUPATION: **CONSTRUCTION**  
CAUSE OF DEATH: **HEART DISEASE**  
DATE OF DEATH: **APR 25, 1957**  
PLACE OF DEATH: **BOSTON**  
HOSPITAL: **SACRED HEART HOSPITAL**  
PHYSICIAN: **DR. J. J. O'NEILL**  
MANNER OF DEATH: **NATURAL**  
SIGNATURE: **JOSEPH JOHN**  
DATE: **APR 25, 1957**

CORRIGANVILLE

JOSEPH JOHN

214-02-3729

BUREAU V. 5

APR 25 1957

RECEIVED

rd, Ms

INSTRUCTIONS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03560

3589

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R. D. # 1 Cumberland, rural</b>		c. LENGTH OF STAY IN 1b <b>x2 R. D. # 1 Cumberland, rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crystal Park</b>		d. STREET ADDRESS <b>Crystal Park</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>AUGUSTUS</b> Last <b>HUBBARD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 27, 1886</b>
9. AGE (In years lost birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R &amp; O Railroad Shops, Houtzdale, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Peter Hubbard</b>		14. MOTHER'S MAIDEN NAME <b>Bridget McCarthy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>155-09-1453</b>	
17. INFORMANT <b>Mrs. Charles Hubbard, R. D. # 1 Cumberland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Coronary insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 mins</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , to <b>4/26</b> , 19 <b>57</b> that I last saw the deceased alive on <b>4/14</b> , 19 <b>57</b> , and that death occurred at <b>4/26</b> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>George M. Simons, M.D. 128 Union St. 4/27/57</b>			
ACTUAL SIGNATURE <b>George M. Simons, M.D.</b>		PHYSICIAN'S NAME (Type) <b>George M. Simons, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 29, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 29, 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>	

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>James Earl Ray</u></p>		<p>2. Date of birth: <u>May 19, 1928</u></p>	
<p>3. Sex: <u>Male</u></p>		<p>4. Race: <u>White</u></p>	
<p>5. Date of death: <u>April 4, 1968</u></p>		<p>6. Place of death: <u>Memphis, Tennessee</u></p>	
<p>7. Cause of death: <u>Shot</u></p>		<p>8. Manner of death: <u>Assault</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Signature of informant: <u>[Signature]</u></p>		<p>12. Signature of medical examiner: <u>[Signature]</u></p>	

**RECEIVED**  
 APR 30 1957  
 BUREAU V. 1

Within corporate limits

DR. VAN ORMER.

3546

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 HR. 35 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>65 WASHINGTON STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>G.</b> Last <b>HUGHES</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 2, 1913</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED EXPLOSIVES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HERCULES POWDER CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>OPERATOR, 1st Class. GRIFFITH HUGHES</b>			
14. MOTHER'S MAIDEN NAME <b>ANNIE REESE</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>216-01-8784</b>				17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis in Hypertension (heart 260x)</b> DUE TO <b>stroke with territorial cerebral aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarction, cont.</b> DUE TO <b>Diabetes mellitus</b> (c) <b>Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>2</b> <b>25 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1860</b> , 1935 to <b>27 Apr.</b> , 1957, that I last saw the deceased alive on <b>27 Apr.</b> , 1957, and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>27 Apr. 57</b>							
ACTUAL SIGNATURE <b>W. A. Van Ormer</b> M.D.				PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Durst Funeral Home, Frostburg, Maryland.</b>				24a. REC'D BY REGISTRAR <b>April 29, 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03562

3547

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. LENGTH OF STAY IN 1b <b>22 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X 2 CUMBERLAND</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>1 ROUTE #1</b>	
3. NAME OF DECEASED (Type or print) <b>First CLAUDE Middle T. Last JETT Jr.</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 17, 1877</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Office Mgr. Undergarment Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>FALMOUTH, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELLIOTT JETT</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. SULLIVAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>317-05-5306</b>	
17. INFORMANT <b>John Jett</b>		Address <b>Cumberland Md.</b>	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Heart disease</b> (c) <b>Emphysema &amp; Stenosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 yrs</b> <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1957</b> to <b>April 28, 1957</b> , that I last saw the deceased alive on <b>April 27, 1957</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. Alan G. Murray M.D.</b>		ADDRESS (Street, city or town, state) <b>Salisbury Md.</b> DATE SIGNED <b>April 28/57</b>	
PHYSICIAN'S NAME (Type) <b>F.A.G. MURRAY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>May 1, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hellcrest Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumb. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumb. Md.</b>	
24a. REC'D BY REGISTRAR <b>April 30, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1895		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 15 1957		BALTIMORE, MARYLAND		HEART DISEASE	
SEX		AGE		OCCUPATION	
MALE		62		RETIRED	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JAN 15 1915		BALTIMORE, MARYLAND	
EDUCATION		SCHOOLING		RELIGION	
HIGH SCHOOL		8		METHODIST	
PREVIOUS ILLNESS		DATE OF ONSET		TREATMENT	
HEART DISEASE		JAN 10 1957		HOSPITAL	
DATE OF EXAMINATION		PLACE OF EXAMINATION		EXAMINER	
JAN 15 1957		BALTIMORE, MARYLAND		J. H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
				J. H. HARRIS	
DATE OF SIGNATURE		PLACE OF SIGNATURE		SIGNATURE OF PHYSICIAN	
JAN 15 1957		BALTIMORE, MARYLAND		J. H. HARRIS	

RECEIVED  
MAY 2 1957  
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3548 CERTIFICATE OF DEATH

Reg. Dist. No. 03503

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2½ HR.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY 85x-3</b>		d. STREET ADDRESS <b>140 MAIN STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>SUSAN</b> Last <b>KRAMPF</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 13, 1886</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>RIDGELEY, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Saml. DIXON</b>		14. MOTHER'S MAIDEN NAME <b>EMMA Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis of blood vessels</b> DUE TO (c) <b>3 hours</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 18, 1950</b> to <b>April 18, 1957</b> that I last saw the deceased alive on <b>April 18, 1957</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D.		ADDRESS (Street, city or town, state) <b>41 Everett Cumberland Md</b> DATE SIGNED <b>4/24/57</b>	
PHYSICIAN'S NAME (Type) <b>B.M. SCHINDLER, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-22-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 22, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W.K. Frank, M.D.</b>	

BUREAU V. 5

APR 24 1957

RECEIVED

1  
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03564

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3549

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>14 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>L.</b> Last <b>Lennan</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13-1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Westernport, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Lennan</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Hanley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Memorial Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO <b>Myocarditis also had</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>903.7</b> DUE TO <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>gradual</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Comminuted introchanteric fracture of right femur</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING* <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>In bathroom, general weakness, fell &amp; injured right leg.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:15 a.m. April 13/57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>County Home</b>		20f. (City or town) (County) (State) <b>Cumberland Allegany Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		DATE SIGNED <b>April 28-1957</b>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boal's Funeral Home, Westernport, Maryland.</b>		24a. REC'D BY REGISTRAR <b>April 29, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W. R. Frantz, M.D.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

3550

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>35 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>304 Bedford St.</b>		d. STREET ADDRESS <b>304 Bedford St.</b>	
3. NAME OF DECEASED (Type or print) <b>Ella</b> <b>First</b> <b>May</b> <b>Last</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4-1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b>	IF UNDER 24 HRS. Hours <b>85</b> Min. <b>85</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Everett Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Allison</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Chamberlin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>(brother) Alvin O. Sutton, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 17-1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 20, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc., Cumberland, Maryland.</b>		24a. REC'D BY REGISTRAR <b>April 18, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W.E. Trautz, M.D.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF NURSE		18. SIGNATURE OF CHAPLAIN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF OTHER	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF JURY	
26. SIGNATURE OF DISTRICT ATTORNEY		27. SIGNATURE OF COUNTY ATTORNEY		28. SIGNATURE OF CITY ATTORNEY		29. SIGNATURE OF TOWNSHIP ATTORNEY		30. SIGNATURE OF VILLAGE ATTORNEY	
31. SIGNATURE OF JUSTICE OF THE PEACE		32. SIGNATURE OF CLERK OF THE COURT		33. SIGNATURE OF SHERIFF OF THE COURT		34. SIGNATURE OF DEPUTY SHERIFF OF THE COURT		35. SIGNATURE OF JURY	
36. SIGNATURE OF DISTRICT CLERK		37. SIGNATURE OF COUNTY CLERK		38. SIGNATURE OF CITY CLERK		39. SIGNATURE OF TOWNSHIP CLERK		40. SIGNATURE OF VILLAGE CLERK	
41. SIGNATURE OF JUSTICE OF THE PEACE		42. SIGNATURE OF CLERK OF THE COURT		43. SIGNATURE OF SHERIFF OF THE COURT		44. SIGNATURE OF DEPUTY SHERIFF OF THE COURT		45. SIGNATURE OF JURY	
46. SIGNATURE OF DISTRICT CLERK		47. SIGNATURE OF COUNTY CLERK		48. SIGNATURE OF CITY CLERK		49. SIGNATURE OF TOWNSHIP CLERK		50. SIGNATURE OF VILLAGE CLERK	

**RECEIVED**  
APR 22 1957  
BUREAU W B

## CERTIFICATE OF DEATH

3551

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland,</u>		<u>6 days</u>		TOWN <u>Keyser, W. Va. 85 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SacredHeart Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. #3</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Elmer</u> (Middle) <u>Long</u> (Last)				(Month) <u>April</u> (Day) <u>25</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 1, 1908</u>	<u>48</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Foreman</u>			<u>Orchard</u>	<u>West Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Addison Long</u>				<u>Callie Arbogast</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>236-50-1310</u>		<u>Patient's Chart.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>acute coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary heart disease</u>				<u>1 month</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-19-</u> , 19 <u>57</u> , to <u>4-25-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-25-</u> , 19 <u>57</u> , and that death occurred at <u>1 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>L. Morris</u>		M.D. <u>5760000 D. Cumberland Md</u>		DATE SIGNED <u>4-26-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 28, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		LOCATION (City, town, or county) (State) <u>Romney, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Winter L. Frantz M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

## INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 10M



1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

03568

Reg. Dist. No. 4

3552

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>PENNA</u>		COUNTY <u>BEDFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>1 hour</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HYNDMAN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>75 X-3</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>J. WARREN MACLAY</u>				<b>4. DATE OF DEATH</b> (Month) <u>APRIL</u> (Day) <u>25</u> (Year) <u>1957</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>Sept 28, 1896</u>	<b>9. AGE last birthday</b> <u>60</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>EDUCATION</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>SHIPPENSBURG, PA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>RALPH F. MACLAY</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNA WARREN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> <u>WWI</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>161-32-9820</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Anna MacLay, Hyndman</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Coronary Thrombosis</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 days</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>April 22, 1957</u>, to <u>April 25, 1957</u>, that I last saw the deceased alive on <u>April 25, 1957</u>, and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John G. Topper</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Hyndman Pa</u>		<b>DATE SIGNED</b> <u>4/26/57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>April 29, 1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hyndman Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Hyndman, Pa.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>April 27, 1957</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Arnter R. Frantz, M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harvey J. Leigler</u>		<b>ADDRESS</b> <u>Hyndman, Pa.</u>	



# CERTIFICATE OF DEATH

1957

FILE NO.

DATE OF DEATH

NAME OF DECEASED  
 SEX  
 AGE  
 RACE  
 BIRTH DATE  
 PLACE OF BIRTH  
 MARRIAGE DATE  
 PLACE OF MARRIAGE  
 OCCUPATION  
 CAUSE OF DEATH  
 PLACE OF DEATH  
 TIME OF DEATH  
 SIGNATURE OF DECEASED  
 SIGNATURE OF WITNESS  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF CORONER  
 SIGNATURE OF JUDGE  
 SIGNATURE OF CLERK

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 SIGNATURE OF DECEASED  
 SIGNATURE OF WITNESS  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF CORONER  
 SIGNATURE OF JUDGE  
 SIGNATURE OF CLERK

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 SIGNATURE OF DECEASED  
 SIGNATURE OF WITNESS  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF CORONER  
 SIGNATURE OF JUDGE  
 SIGNATURE OF CLERK

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
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DATE OF DEATH  
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 SIGNATURE OF JUDGE  
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DATE OF DEATH  
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 PLACE OF DEATH  
 SIGNATURE OF DECEASED  
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DATE OF DEATH  
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 SIGNATURE OF CORONER  
 SIGNATURE OF JUDGE  
 SIGNATURE OF CLERK

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 SIGNATURE OF DECEASED  
 SIGNATURE OF WITNESS  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF CORONER  
 SIGNATURE OF JUDGE  
 SIGNATURE OF CLERK

BUREAU V. S.

APR 30 1957

RECEIVED

3590

## CERTIFICATE OF DEATH

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Luke</b>				c. LENGTH OF STAY IN 1b <b>42 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>303 Pratt St.</b>				e. STREET ADDRESS <b>303 Pratt St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Myrtle</b> Last <b>Maphis</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1893</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Keyser, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Sheetz</b>				14. MOTHER'S MAIDEN NAME <b>Alberta Walters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Kenneth Maphis Luke, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degeneration not specified as Rheumatic</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) <b>Chronic Myocarditis and Myocardial</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b> <b>1 Year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Dec. 10, 1955</b> to <b>Apr. 7, 1957</b> , that I last saw the deceased alive on <b>Apr. 2, 1957</b> , and that death occurred at <b>12:15 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Piedmont, W. Va.</b> DATE SIGNED <b>Apr. 8, 1957</b>							
ACTUAL SIGNATURE <b>Paul R. Wilson</b>		M.D. <b>Piedmont, W. Va.</b>		DATE SIGNED <b>Apr. 8, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/10/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ebanizer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Hampshire County-W. Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. Bral</b>		ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4-8-57</b>	24b. REGISTRAR'S SIGNATURE <b>John C. Kelly</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2100

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.		1925		BALTIMORE, MD.		HEART DISEASE		NATURAL		1234	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		OCCUPATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		SPECIAL INSTRUCTIONS		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		LABORER		METHODIST		DEMOCRAT		NONE		NONE		J. H. HARRIS	
DATE OF INTERVIEW		INTERVIEWER		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		SIGNATURE OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1925		J. H. HARRIS		1925		BALTIMORE, MD.		HEART DISEASE		NATURAL		1234		J. H. HARRIS		1925		BALTIMORE, MD.		HEART DISEASE	

BUREAU V. S.

APR 9 1957

RECEIVED

3591

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>			c. LENGTH OF STAY IN 1b <b>80 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b> <b>x2</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Railroad St.</b>				d. STREET ADDRESS <b>Railroad St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>McDonald</b> Last <b>McDonald</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 15, 1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Barton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John James McDonald</b>				14. MOTHER'S MAIDEN NAME <b>Sara Ann Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Eileen McDonald</b> Address <b>Barton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b> <b>10 Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar. 15, 1957</b> , to <b>Apr. 16, 1957</b> , that I last saw the deceased alive on <b>Apr. 15, 1957</b> , and that death occurred at <b>12:55 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul R. Wilson</b> M.D.				ADDRESS (Street, city or town, state) <b>Bedmont, W. Va.</b> DATE SIGNED <b>4-17-57</b>			
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>El Boal</b> ADDRESS <b>Westernport, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>4-18-57</b>		24b. REGISTRAR'S SIGNATURE <b>John C Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3592 CERTIFICATE OF DEATH

03570

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>				c. LENGTH OF STAY IN 1b <b>62 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>A.</b> Last <b>McGeady</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 24, 1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Lenaconing, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John P. McGeady</b>				14. MOTHER'S MAIDEN NAME <b>Nora Duggan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-01-6672</b>		17. INFORMANT <b>John McGeady</b>		Address <b>Louisville, Kentucky.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Congestive heart failure</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Main St</b>		(County) (State)	
21. I certify that I attended the deceased from <b>April 5, 1957</b> , to <b>April 17, 1957</b> , that I last saw the deceased alive on <b>April 12, 1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main St Lenaconing Md.</b> DATE SIGNED <b>4.18.57</b>							
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Michaels Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lenaconing, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/20/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Jannette M. Boul</b>			

CERTIFICATE OF DEATH

Name of Deceased <b>John I. Kennedy</b>		Sex <b>Male</b>		Date of Birth <b>May 24, 1872</b>	
Race <b>White</b>		Height <b>5' 10"</b>		Weight <b>175</b>	
Occupation <b>Coal Miner</b>		Education <b>Completed High School</b>		Nationality <b>U.S.A.</b>	
Place of Birth <b>North Duxbury</b>		Date of Death <b>May 24, 1957</b>		Time of Death <b>10:30 P.M.</b>	
Cause of Death <b>Heart Disease</b>		Manner of Death <b>Natural</b>		Signature of Physician <b>John I. Kennedy</b>	
Signature of Registrar <b>John I. Kennedy</b>		Signature of Coroner <b>John I. Kennedy</b>		Signature of Medical Examiner <b>John I. Kennedy</b>	

BUREAU A. E.

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03571

3580

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MINCAS</u>		d. STREET ADDRESS <u>162 W. Mechanic</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>McGuire</u> Last <u>McGuire</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14 57</u>
9. AGE (In years lost birthday) yrs. <u>8</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>1</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Joseph James McGuire</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Winebreaker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. D. Winebreaker Frostburg</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/14</u> , 19 <u>57</u> , to <u>4/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>57</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Devers</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg MD</u> DATE SIGNED <u>4/15/57</u>	
PHYSICIAN'S NAME (Type) <u>John C. Devers</u>		<u>Frostburg MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Devers</u>		ADDRESS <u>62 W. Mechanic</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>4-15-57</u>		<u>—</u>	

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DR. LEWIS

3553 CERTIFICATE OF DEATH

Reg. Dist. No.

03572

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO BARTON RT. #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle Lost MEESE		4. DATE OF DEATH Month APRIL Day 9 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 13, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME NELSON MEESE		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME SIGLER, MARY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia and cachexia DUE TO 175X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis - generalized DUE TO (c) Carcinoma of right ovary			INTERVAL BETWEEN ONSET AND DEATH about 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 25, 1957, to April 9, 1957, that I last saw the deceased alive on April 8, 1957, and that death occurred at 2:50A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Lewis		M.D. 5 Washington St	
PHYSICIAN'S NAME (Type) DR. LEWIS		Cumberland Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 11, 1957	22c. NAME OF CEMETERY OR CREMATORY Meese Family Cemetery	22d. LOCATION (City, town, or county) (State) near Lonaconing, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Boal Funeral Home, Westernport, Maryland.		24a. REC'D BY REGISTRAR April 10, 1957	
		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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3554

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLOTTE</b> Middle <b>S.</b> Last <b>MORGAN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 19, 1906</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sawmill Owner (Retired) and Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Penn. Bedford Valley</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Miller</b>				14. MOTHER'S MAIDEN NAME <b>Christine Hansel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Chart Sacred Heart Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic heart</b> DUE TO (c) <b>Coronary Artery</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>20 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4-3-</b> , 19 <b>52</b> , to <b>4-16-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-15</b> , 19 <b>57</b> , and that death occurred at <b>9:30</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Brings</b>				ADDRESS (Street, city or town, state) <b>57 Green St.</b>			
DATE SIGNED <b>4-16-57</b>							
PHYSICIAN'S NAME (Type) <b>L. Brings, M.D.</b>				Green Street, Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prosperity Meth. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>				24a. REC'D BY REGISTRAR <b>April 19, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Hantz, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

## CERTIFICATE OF DEATH

322A

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03574

3593

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. LENGTH OF STAY IN 1b <b>47 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Douglas Avenue</b>				d. STREET ADDRESS <b>Douglas Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Robert Moses</b>				4. DATE OF DEATH Month Day Year <b>April 14 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1909</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Robert Moses</b>			
14. MOTHER'S MAIDEN NAME <b>Viola Barnes</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>214-07-3588</b>				17. INFORMANT <b>Mrs. Robert Moses</b> Address <b>Lonaconing, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 2, 1957</b> to <b>April 14, 1957</b> , that I last saw the deceased alive on <b>April 7, 1957</b> , and that death occurred at <b>9 a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Jessie R. Miles</b> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/17/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> Address <b>Lonaconing, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>4/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Janneth M Boal</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED <b>James Robert Moore</b>		DATE OF BIRTH <b>July 17, 1909</b>	
RESIDENCE <b>Douglas Avenue</b>		CITY <b>Baltimore</b>	
OCCUPATION <b>Foreman</b>		CAUSE OF DEATH <b>White</b>	
PLACE OF DEATH <b>Home</b>		DATE OF DEATH <b>April 14, 1957</b>	
NAME OF NEXT OF KIN <b>Robert Moore</b>		ADDRESS OF NEXT OF KIN <b>1412-07-3888 Mr. Robert Moore</b>	
NAME OF DECEASED <b>Viola Barnes</b>		DATE OF BIRTH <b>July 17, 1909</b>	
RESIDENCE <b>Douglas Avenue</b>		CITY <b>Baltimore</b>	
OCCUPATION <b>Foreman</b>		CAUSE OF DEATH <b>White</b>	
PLACE OF DEATH <b>Home</b>		DATE OF DEATH <b>April 14, 1957</b>	
NAME OF NEXT OF KIN <b>Robert Moore</b>		ADDRESS OF NEXT OF KIN <b>1412-07-3888 Mr. Robert Moore</b>	

BUREAU V. 2

APR 22 1957

RECEIVED



3555

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

Within corporate limits

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>777 Fayette St.,</b>		d. STREET ADDRESS <b>1 777 Fayette St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Bertha</b> Last <b>Mothersole</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24,</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Jacob Bender</b>		14. MOTHER'S MAIDEN NAME <b>DesNelda Reinhard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Frederick A. Puderbaugh 777 Fayette St.,</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Angina Pectoris</b> DUE TO <b>420.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Heart Disease</b> DUE TO <b>10 years</b> (c) <b>Chronic disease of Heart</b> <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 23, 1957</b> to <b>April 24, 1957</b> , that I last saw the deceased alive on <b>April 23, 1957</b> , and that death occurred at <b>2:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Narrows Park, La Vale, Md.</b> DATE SIGNED <b>W. R. Frank, M.D.</b>			
ACTUAL SIGNATURE <b>F. A. G. Murray</b>		M.D. <b>La Vale, Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>F. A. G. Murray M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>April 26, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Frank, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

APR 29 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

3556

## CERTIFICATE OF DEATH

03576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>35 MIN.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>423 BEALL STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MINNIE L. MULLIN</b>				4. DATE OF DEATH Month Day Year <b>APRIL 25 1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 11, 1886</b>		9. AGE (In years last birthday) <b>71 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Spring Gap</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HIRAM M. LITTLE</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE HERPICH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cerebrovascular Disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 hours.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April</b> , 19 <b>57</b> , to <b>April</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>April 25</b> , 19 <b>57</b> , and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>133 Virginia Ave, Cumberland, Md</b> DATE SIGNED <b>4/26/57</b>							
ACTUAL SIGNATURE <b>Dr. Overton Himmelwright</b>		M.D. <b>133 Virginia Ave, Cumberland, Md</b>					
PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>April 27, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>E. R. Frantz, M.D.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1992

10. *Journal of the American Statistical Association*, 92, 1997, 1033-1041.

— 147.507.241.52 —

BUREAU V. S.

APR 30 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

3557

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>1 hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Old Town</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>Charles</b> Last <b>Nixon</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20-1939</b>
9. AGE (In years last birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.	IF UNDER 24 HRS. Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Nixon</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Crabtree</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-36-6686</b>	
17. INFORMANT (father) <b>Charles Nixon, Old Town, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intrathoracic hemorrhage</b> <b>823x</b> DUE TO <b>Crushed</b> Conditions, if any, which gave rise to immediate cause (b) <b>Crushed chest (left side)</b> DUE TO (c) <b>Crushed chest (left side)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Driver lost control of car &amp; hit a tree in W.Va.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver lost control of car &amp; hit a tree in W.Va.</b>	
20c. TIME OF INJURY Month, Day, Year <b>April 27, 1957</b> Hour <b>9:15</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway, near Green Spring</b>		20f. (City or town) <b>W.Va.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H.V. Deming</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 28-1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 30, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>April 29, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Frantz, M.D.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		1957-04-10		BOSTON, MASS.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St., Boston, Mass.		Carpenter		High School		Married		Heart Disease		Natural	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		LABORATORY EXAMINATIONS		POST-MORTEM EXAMINATION	
None		None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		HOSPITAL		CITY	
J. J. Jones		1957-04-10		10:00 AM		Boston, Mass.		None		Boston	

BUREAU V. S.

APR 30 1957

RECEIVED

CERTIFICATE OF DEATH

03578

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>80 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1105 1/2 Virginia Avenue</b>				d. STREET ADDRESS <b>1105 1/2 Virginia Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Ellen</b> Last <b>Orndoff</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1871</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Winchester, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Rinker</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Jane Rosenberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Miss Mamie Orndoff, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Stage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/4/57</b> , 19____, to <b>4/6/57</b> , 19____, that I last saw the deceased alive on <b>4/5/57</b> , 19____, and that death occurred at <b>3:35</b> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>4/8/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 9, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Moorefield, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>April 9, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1957

RECEIVED

3581

## CERTIFICATE OF DEATH

Reg. Dist. No.

03579

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zihlman Box T3I X 0</u>			
c. LENGTH OF STAY IN 1b <u>9 Days</u>				d. STREET ADDRESS <u>R. D. No 2 Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William H. Porter</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-1885</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Zihlman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Porter</u>				14. MOTHER'S MAIDEN NAME <u>Mahila Crowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>R.D.#2 Box 131 Mrs. Wm. N. Porter Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Prostate gland about 1 yr.</u> 177K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <input checked="" type="checkbox"/>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>	
20f. (City or town) <u>Frostburg</u> (County) <u>Allegany</u> (State) <u>Md.</u>							
21. I certify that I attended the deceased from <u>AUG. 14, 1956</u> to <u>APRIL 3, 1957</u> that I last saw the deceased alive on <u>APRIL 3, 1957</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>48 BROADWAY, FROSTBURG, MD.</u> DATE SIGNED <u>4/3/57</u>							
ACTUAL SIGNATURE <u>Martin M. Rothstein</u> M.D. <u>48 BROADWAY, FROSTBURG, MD.</u>							
PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Winters</u> ADDRESS <u>Hafer Funeral Home 23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Nancy N. Rose</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





3559

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>4 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>204 Virginia Ave.</b>				d. STREET ADDRESS <b>204 Virginia Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Montary</b> Middle <b>Puffinburger</b> Last <b></b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1878</b>		9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Harrisonburg, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Puffinburger</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Shade</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Waldo Puffinburger, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Maemia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) <b>Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 15, 1957</b> , to <b>Apr. 19, 1957</b> , that I last saw the deceased alive on <b>Apr. 18, 1957</b> , and that death occurred at <b>7:30 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay E. Durrett</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>236 Vg. Cms Cumberland Md 4/20/57</b>			
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Points, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				ADDRESS <b>April 22, 1957</b>		24a. REC'D BY REGISTRAR <b>W.R. Frantz, M.D.</b>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN E. SMITH		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF DEATH April 20, 1957		6. TIME OF DEATH 10:30 AM		7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural		10. SIGNATURE OF PHYSICIAN J. E. Smith		11. SIGNATURE OF REGISTRAR J. E. Smith		12. SIGNATURE OF DECEASED J. E. Smith	
13. BIRTH DATE 1912		14. BIRTH PLACE Maryland		15. BIRTH TIME 10:30 AM		16. BIRTH PLACE Maryland		17. BIRTH TIME 10:30 AM		18. BIRTH PLACE Maryland		19. BIRTH TIME 10:30 AM		20. BIRTH PLACE Maryland		21. BIRTH TIME 10:30 AM		22. BIRTH PLACE Maryland		23. BIRTH TIME 10:30 AM		24. BIRTH PLACE Maryland	
25. BIRTH DATE 1912		26. BIRTH PLACE Maryland		27. BIRTH TIME 10:30 AM		28. BIRTH PLACE Maryland		29. BIRTH TIME 10:30 AM		30. BIRTH PLACE Maryland		31. BIRTH TIME 10:30 AM		32. BIRTH PLACE Maryland		33. BIRTH TIME 10:30 AM		34. BIRTH PLACE Maryland		35. BIRTH TIME 10:30 AM		36. BIRTH PLACE Maryland	
37. BIRTH DATE 1912		38. BIRTH PLACE Maryland		39. BIRTH TIME 10:30 AM		40. BIRTH PLACE Maryland		41. BIRTH TIME 10:30 AM		42. BIRTH PLACE Maryland		43. BIRTH TIME 10:30 AM		44. BIRTH PLACE Maryland		45. BIRTH TIME 10:30 AM		46. BIRTH PLACE Maryland		47. BIRTH TIME 10:30 AM		48. BIRTH PLACE Maryland	
49. BIRTH DATE 1912		50. BIRTH PLACE Maryland		51. BIRTH TIME 10:30 AM		52. BIRTH PLACE Maryland		53. BIRTH TIME 10:30 AM		54. BIRTH PLACE Maryland		55. BIRTH TIME 10:30 AM		56. BIRTH PLACE Maryland		57. BIRTH TIME 10:30 AM		58. BIRTH PLACE Maryland		59. BIRTH TIME 10:30 AM		60. BIRTH PLACE Maryland	
61. BIRTH DATE 1912		62. BIRTH PLACE Maryland		63. BIRTH TIME 10:30 AM		64. BIRTH PLACE Maryland		65. BIRTH TIME 10:30 AM		66. BIRTH PLACE Maryland		67. BIRTH TIME 10:30 AM		68. BIRTH PLACE Maryland		69. BIRTH TIME 10:30 AM		70. BIRTH PLACE Maryland		71. BIRTH TIME 10:30 AM		72. BIRTH PLACE Maryland	
73. BIRTH DATE 1912		74. BIRTH PLACE Maryland		75. BIRTH TIME 10:30 AM		76. BIRTH PLACE Maryland		77. BIRTH TIME 10:30 AM		78. BIRTH PLACE Maryland		79. BIRTH TIME 10:30 AM		80. BIRTH PLACE Maryland		81. BIRTH TIME 10:30 AM		82. BIRTH PLACE Maryland		83. BIRTH TIME 10:30 AM		84. BIRTH PLACE Maryland	
85. BIRTH DATE 1912		86. BIRTH PLACE Maryland		87. BIRTH TIME 10:30 AM		88. BIRTH PLACE Maryland		89. BIRTH TIME 10:30 AM		90. BIRTH PLACE Maryland		91. BIRTH TIME 10:30 AM		92. BIRTH PLACE Maryland		93. BIRTH TIME 10:30 AM		94. BIRTH PLACE Maryland		95. BIRTH TIME 10:30 AM		96. BIRTH PLACE Maryland	
97. BIRTH DATE 1912		98. BIRTH PLACE Maryland		99. BIRTH TIME 10:30 AM		100. BIRTH PLACE Maryland		101. BIRTH TIME 10:30 AM		102. BIRTH PLACE Maryland		103. BIRTH TIME 10:30 AM		104. BIRTH PLACE Maryland		105. BIRTH TIME 10:30 AM		106. BIRTH PLACE Maryland		107. BIRTH TIME 10:30 AM		108. BIRTH PLACE Maryland	
109. BIRTH DATE 1912		110. BIRTH PLACE Maryland		111. BIRTH TIME 10:30 AM		112. BIRTH PLACE Maryland		113. BIRTH TIME 10:30 AM		114. BIRTH PLACE Maryland		115. BIRTH TIME 10:30 AM		116. BIRTH PLACE Maryland		117. BIRTH TIME 10:30 AM		118. BIRTH PLACE Maryland		119. BIRTH TIME 10:30 AM		120. BIRTH PLACE Maryland	

BUREAU V. 1

APR 24 1957

RECEIVED

3594

## CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Borden Mines</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg, Md. X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. #2, Frostburg, Md.</u>				d. STREET ADDRESS <u>R.D. #2, Box 183</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JAMES</u>		First Middle Last <u>RANKIN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Zihlman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Rankin</u>				14. MOTHER'S MAIDEN NAME <u>Edith Shoemaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>216-30-2085</u>		17. INFORMANT <u>R.D. #2, Box 183</u> <u>Mrs. Mabel Rankin, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm Left Renal Artery</u> <u>452x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 22, 1957</u> , to <u>Apr 22, 1957</u> , that I last saw the deceased alive on <u>Apr 20, 1957</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>WOMC Lane</u>		M.D. <u>Frostburg</u>		ADDRESS (Street, city or town, state) <u>MD</u>		DATE SIGNED <u>Apr 24 1957</u>	
PHYSICIAN'S NAME (Type) <u>WOMC Lane MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-25-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burial H. Winters</u>				ADDRESS <u>Hafer funeral Home</u>		24a. REC'D BY REGISTRAR <u>4-25-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Miss Nancy N. Roe</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>1-1-1900</i>	
SEX <i>Male</i>		RACE <i>White</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, Md.</i>	
DATE OF DEATH <i>4-15-1957</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
DATE OF REPORT <i>4-16-1957</i>		REPORTED BY <i>Dr. J. Smith</i>	

BUREAU V. 2

APR 29 1957

RECEIVED

3595

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, rural</b>			c. LENGTH OF STAY IN 1b <b>34 years</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Baltimore Pike, R.F.D. #2</b>			d. STREET ADDRESS <b>Baltimore Pike, R.F.D. #2</b>		
3. NAME OF DECEASED (Type or print) <b>Edith May Rice</b>			4. DATE OF DEATH <b>April 10 19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/91</b>		9. AGE (In years lost birthday) <b>65 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper at Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Avilton Md.</b>
13. FATHER'S NAME <b>? Robison</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Robison</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Carl Rice Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Hemiplegia</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2-3 mon</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/6/57</b> to <b>4-10-57</b> , that I last saw the deceased alive on <b>4-3-57</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W.R. Hodges</b>		ADDRESS (Street, city or town, state) <b>Cumberland Md</b>		DATE SIGNED <b>4/11/57</b>	
PHYSICIAN'S NAME (Type) <b>W.R. Hodges, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 11, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**RECEIVED**  
 APR 12 1957  
 BUREAU V. 1

MARSHALL STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH	
Name Alice Amy	Name Mary Ann
Date of Birth 04/10/1901	Date of Birth 04/10/1901
Sex Female	Sex Female
Race White	Race White
Occupation None	Occupation None
Cause of Death (To be filled in by physician)	Cause of Death (To be filled in by physician)
Date of Death 04/10/1957	Date of Death 04/10/1957
Place of Death (To be filled in by physician)	Place of Death (To be filled in by physician)
Signature of Physician (To be filled in by physician)	Signature of Physician (To be filled in by physician)
Signature of Registrar (To be filled in by registrar)	Signature of Registrar (To be filled in by registrar)

3560

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>M</b> Last <b>RICE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 27, 1881</b>	
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>FROSTBURG, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ADAM KRAUSS</b>				14. MOTHER'S MAIDEN NAME <b>ANNA VOGTMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>Memorial Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardiovascular disease</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> (c) <b>Chronic Cholecystitis &amp; Cholelithiasis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cholecystitis &amp; Cholelithiasis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>11.29.1956</b> to <b>4.27.1957</b> , that I last saw the deceased alive on <b>4.27.1957</b> , and that death occurred at <b>2:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>4.29.57</b>							
ACTUAL SIGNATURE <b>W. F. Williams</b> M.D.				PHYSICIAN'S NAME (Type) <b>W.F. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 30, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Evangelical &amp; Reformed Cen., Frostburg, Maryland</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Durst Funeral Home, Frostburg, Maryland.</b>				24a. REC'D BY REGISTRAR <b>April 29, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Krantz, M.D.</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		APRIL 10, 1957	
AGE		SEX	
65		MALE	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
BIRTHPLACE		OCCUPATION	
MARYLAND		RETIRED	
MARRIAGE		CAUSE OF DEATH	
MARRIED		HEART DISEASE	
DATE OF MARRIAGE		PLACE OF DEATH	
JANUARY 15, 1920		HOME	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME	
DR. J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 10, 1957		APRIL 10, 1957	

BUREAU V. S.

APR 30 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03584

Reg. Dist. No.

3596

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural- Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural- Cumberland</u> <u>x2</u>			
c. LENGTH OF STAY IN 1b <u>15 yrs</u>				d. STREET ADDRESS <u>Rt. # 4 Old Town Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. # 4 Old Town Road *-D.O.A.</u> <u>the Memorial Hospital.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Emory</u> Last <u>Robinette</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29-1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carman helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O R.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Robinette</u>				14. MOTHER'S MAIDEN NAME <u>Laura Valentine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>220-10-0622</u>		17. INFORMANT <u>2(brother) Geo. A. Robinette, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 8-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>April 9, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file this certificate with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file this certificate with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 11 1957

RECEIVED



3561

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			d. STREET ADDRESS <b>105 SOUTH LEE ST.,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>RANDOLPH</b> Middle <b>ROBINETTE</b> Last <b>ROBINETTE</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>19 57</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 18, 1892</b>		9. AGE (In years last birthday) yrs. <b>64</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet metal &amp; Pipe Fitter Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>43</b>	11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ELI ROBINETTE</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA WILSON</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>War 1.</b>		16. SOCIAL SECURITY NO. <b>705-09-9643</b>	17. INFORMANT <b>Mrs. Amanda Robinette</b> Address <b>Cumberland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Exhaustion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Three episodes of Myocardial</b> DUE TO <b>infarction</b> (c) <b>infarction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>8/15/38</b> , 19____, to <b>4/28/57</b> , 19____, that I last saw the deceased alive on <b>4/27/57</b> , 19____, and that death occurred at <b>7:30 A. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>R. J. Williams</b>			DATE SIGNED <b>4/28/57</b>		
PHYSICIAN'S NAME (Type) <b>R. J. WILLIAMS</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-30-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HillCrest Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> Address <b>Cumberland, Md.</b>			24a. REC'D BY REGISTRAR <b>April 29, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Franky, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**0-7893-7561-5**

— 12 —

1000-290-07

BUREAU W. 2

APR 30 1957

RECEIVED

3582

## CERTIFICATE OF DEATH

03586

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>E.</b> Last <b>ROBISON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> , Year <b>57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 1, 1891</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired - calendar room</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Spgfd. Tire</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joshua Robison</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Sinnet</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-05-9886</b>		17. INFORMANT <b>Mrs. Martha Hewitt, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Evisceration (postoperative)</b> <b>57.1.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Illness</b> DUE TO (c) <b>Subacute Colitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>4 days</b> <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 24, 1957</b> , to <b>April 15, 1957</b> , that I last saw the deceased alive on <b>April 15, 1957</b> , and that death occurred at <b>2:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Hilda Jane Walters MD</b>				ADDRESS (Street, city or town, state) <b>48 Broadway, Frostburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Hilda Jane Walters MD</b>				DATE SIGNED <b>4/16/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-17-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>4-17-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Mary A. Rose</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CORONER [Illegible]		SIGNATURE OF JURY [Illegible]		SIGNATURE OF JUDGE [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CHIEF OF BUREAU [Illegible]	

BUREAU V. 8

APR 22 1957

RECEIVED

Within corporate limits

3562

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>811 Broddock Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>F.</u> Last <u>Schmütz</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 15, 1891</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles A. Schmütz</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Messman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Mrs. Ester Schmütz</u>		Address <u>Cumb Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>57</u> , to <u>April 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>57</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo H. Ley, Jr.</u>				M.D. <u>452 N. Centre St.</u>		DATE SIGNED <u>4/30/57</u>	
PHYSICIAN'S NAME (Type) <u>LEO H. LEY, JR.</u>				<u>Cumberland Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 1, 1957</u>		<u>SS Peter + Paul</u>		<u>Cumb Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumb Md.</u>		24a. REC'D BY REGISTRAR <u>May 1, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		Acting Deputy State Health Officer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

**BUREAU V. 3.**

MAY 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be attached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03588

3597

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Rural Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RE #6 Box 66</u>		d. STREET ADDRESS <u>1 RE #6 Box 66</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>John</u> Last <u>Schoenadel</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1877</u>
9. AGE (in years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Patterson Creek W Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Schoenadel</u>		14. MOTHER'S MAIDEN NAME <u>Clara (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, indicate unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. J. J. Schoenadel La Vale Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension Heart Disease</u> <u>467.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>2 yrs</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 1956, to <u>April 7, 1957</u> , that I last saw the deceased alive on <u>April 8, 1957</u> , and that death occurred at <u>1:30 a. m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. Alan G. Murray</u> M.D.		DATE SIGNED <u>La Vale Md.</u>	
PHYSICIAN'S NAME (Type) <u>F. Alan G. Murray, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul's</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>Phil 10, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>			

CERTIFICATE OF DEATH

NAME - LAST, FIRST, MIDDLE SEX - <input type="checkbox"/> Male <input type="checkbox"/> Female DATE OF BIRTH - <input type="text"/>		PLACE OF BIRTH - <input type="text"/> COUNTY - <input type="text"/>	
OCCUPATION - <input type="text"/> PRESENT ADDRESS - <input type="text"/> HOME PHONE - <input type="text"/>		DEATH DATE - <input type="text"/> DEATH TIME - <input type="text"/> DEATH PLACE - <input type="text"/>	
CAUSE OF DEATH - <input type="text"/> ICD CODE - <input type="text"/>		MANNER OF DEATH - <input type="text"/> REPORTED BY - <input type="text"/>	
SIGNATURE OF PHYSICIAN - <input type="text"/> DATE - <input type="text"/>		SIGNATURE OF REGISTRAR - <input type="text"/> DATE - <input type="text"/>	

BUREAU V. 31

APR 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3563

## CERTIFICATE OF DEATH

Reg. Dist. No.

03589

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>5 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Edward</b> Last <b>Sell</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 16, 1895</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner Brick Yard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Brick &amp; Supply Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George Sell (Deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Sullivan (Deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. 1</b>		17. INFORMANT <b>Mrs. Norman Sell, 305 Mt. View Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>57</b> , to <b>April</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>April 7</b> , 19 <b>57</b> , and that death occurred at <b>12:15 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. Centre St., Cumberland, Md.</b> DATE SIGNED <b>4/7/57</b>							
ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b>		M.D. <b>Leo H. Ley Jr., M.D.</b>					
PHYSICIAN'S NAME (Type) <b>Leo H. Ley Jr., M.D.</b>		<b>456 N. Centre St., Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>April 9, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Frank M.D.</b>	

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APR 11 1957

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## 3564 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1027 Braddock Road</b>				d. STREET ADDRESS <b>1027 Braddock Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Smith</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4-1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.	IF UNDER 24 HRS. Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired employee - Rosenbaum Dept. Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phillip Smith</b>				14. MOTHER'S MAIDEN NAME <b>Christine Nickel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-6183</b>		17. INFORMANT <b>(son) Charles Smith, LaVale, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>?</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H.V. Deming</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 2-1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Steier, Inc</b>				ADDRESS <b>Cumberland Md.</b>		24a. REC'D BY REGISTRAR <b>April 3, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. R. [Signature]</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

3565

CERTIFICATE OF DEATH

03591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>5 1/2 HR.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				d. STREET ADDRESS <b>1 BOULEVARD APARTMENTS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BOY</b> Middle <b>BOY</b> Last <b>SOCKS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 3, 1957</b>		9. AGE (In years last birthday) yrs. <b>5</b> Min. <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT H. SOCKS</b>				14. MOTHER'S MAIDEN NAME <b>EDNA R. FURRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Fuller B. Whitworth</b>				DATE SIGNED <b>April 5, 1957</b>			
PHYSICIAN'S NAME (Type) <b>FULLER B. WHITWORTH, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>April 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital, Cumberland, Md</b>				24a. REC'D BY REGISTRAR <b>April 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Frantz, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED ROBERT H. JOCKS		DATE OF DEATH APR 7 1957	
AGE 37		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
BIRTH DATE APR 10 1920		BIRTH PLACE BALTIMORE, MARYLAND	
MARRIAGE MARRIED		SPOUSE'S NAME EDNA E. JOCKS	
OCCUPATION FIREMAN		PLACE OF DEATH HOME	
CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. JOCKS		SIGNATURE OF WITNESSES J. H. JOCKS, EDNA E. JOCKS	
DATE OF SIGNATURE APR 7 1957		PLACE OF SIGNATURE BALTIMORE, MARYLAND	

**RECEIVED**  
APR 8 1957  
BUREAU V. 1

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

3583

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
f. STREET ADDRESS <b>160 Ormond St.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ALVIN</b> Last <b>SPITZNAS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1890</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dye House</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Spitznas</b>		14. MOTHER'S MAIDEN NAME <b>Martha Lemmert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>212-24-1148</b>	
17. INFORMANT <b>Edna Spitznas, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular renal disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/24</b> , 19 <b>57</b> , to <b>4/24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-25</b> , 19 <b>57</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. C. Diehl</b>		M.D. <b>Frostburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John B. Davis, M. D.</b>		DATE SIGNED <b>4/26/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-27-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>4-27-57</b> 24b. REGISTRAR'S SIGNATURE <b>W. Nancy H. Lee</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. No. 100

1. NAME OF DECEASED ALFRED J. ALLEN		2. SEX MALE		3. AGE 40		4. RACE WHITE		5. PLACE OF BIRTH BALTIMORE, MD.	
6. DATE OF DEATH MAY 2, 1957		7. TIME OF DEATH 10:00 AM		8. PLACE OF DEATH HOME		9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. SIGNATURE OF DECEASED ALFRED J. ALLEN		12. SIGNATURE OF NEXT OF KIN MRS. J. ALLEN		13. SIGNATURE OF PHYSICIAN DR. J. ALLEN		14. SIGNATURE OF REGISTRAR J. ALLEN		15. SIGNATURE OF CLERK J. ALLEN	

BUREAU V. 3

MAY 2 1957

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4-11-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03593

3566

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>45 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>302 Cumberland St.</b>		d. STREET ADDRESS <b>302 Cumberland St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Stegmaier</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7, 1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Elk Garden, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Kelley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Melody</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Harry I. Stegmaier, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>57</b> , to <b>4/17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/17</b> , 19 <b>57</b> , and that death occurred at <b>10:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. Centre St. Cumberland, Md.</b> DATE SIGNED <b>4/19/57</b> ACTUAL SIGNATURE <b>Leo H. Lex Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>LEO H. LEX JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-22-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 22, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W.R. Frank M.D.</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HENRY		Male		45		1910		BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MD.		10:30 AM		J. H. HENRY		J. H. HENRY	
13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS TOXIC		17. PREVIOUS INFECTION		18. PREVIOUS OTHER		19. PREVIOUS OTHER		20. PREVIOUS OTHER		21. PREVIOUS OTHER		22. PREVIOUS OTHER		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	
25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER		45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER		56. PREVIOUS OTHER		57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. 5

APR 24 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3598

## CERTIFICATE OF DEATH

03594

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u>		c. LENGTH OF STAY IN 1b <u>59 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>B.</u> Last <u>Steiding</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp</u>	9. AGE (In years last birthday) <u>67</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Elk Garden, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Steiding</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McLaughlin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-07-3803</u>	
17. INFORMANT <u>John Steiding</u>		Address <u>Lonaconing, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>57</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Main St Lonaconing Md.</u> DATE SIGNED <u>4.5.57</u>			
ACTUAL SIGNATURE <u>Leslie R. Miles</u> M.D.		22. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F Cemetery</u>	
PHYSICIAN'S NAME (Type) <u>LESLIE R. MILES JR.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/57</u>	
22c. LOCATION (City, town, county) (State) <u>Elk Garden W.Va.</u>		24a. REC'D BY REGISTRAR DATE <u>4/6/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Jeannette M Boal</u>			

CERTIFICATE OF DEATH

2808

Form 10-1-54

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		JAN 5, 1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL		CITY	
APR 4, 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		APR 6, 1968		MOBILE, ALABAMA		MOBILE	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF MORTUARY		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF MINISTER		NAME OF CLERGYMAN	
DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF PATHOLOGIST		SIGNATURE OF MORTUARY		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		PLACE		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
APR 11, 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		APR 11, 1968		MOBILE, ALABAMA		MOBILE	

BUREAU V. S.

APR 11 1968

RECEIVED





# CERTIFICATE OF DEATH

1957

DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS		COUNTY OF MARYLAND CITY OF BALTIMORE	
NAME OF DECEASED JAMES EARL RAY		SEX MALE	
DATE OF BIRTH JANUARY 5, 1928		PLACE OF BIRTH MOBILE, ALABAMA	
DATE OF DEATH APRIL 4, 1968		PLACE OF DEATH MEMPHIS, TENNESSEE	
TIME OF DEATH 1:00 PM		CAUSE OF DEATH ASSAULT BY FIRE	
MANNER OF DEATH SUICIDE		PLACE OF INTERMENT GREENWICH CEMETERY, BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. 3

APR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03596

3600

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Westernport</b>				c. LENGTH OF STAY IN 1b <b>64 Yrs</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Westernport-Rural</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1 Mi. N. Westernport</b>				d. STREET ADDRESS <b>1 Mi. N. Westernport</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Elmer</b> First Middle Last <b>Lee Trenum</b>				4. DATE OF DEATH <b>April</b> Month <b>22</b> Day <b>1957</b> Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1892</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Westernport, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jefferson Trenum</b>				14. MOTHER'S MAIDEN NAME <b>Katherine McManus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-12-8111</b>		17. INFORMANT Address <b>William Trenum-Westernport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>415X Chronic Myocarditis with Edema</b> DUE TO <b>Rheumatic Fever</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>50 Years</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Two Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan. 20</b> , 1957, to <b>Apr. 22</b> , 1957, that I last saw the deceased alive on <b>Apr. 27</b> , 1957, and that death occurred at <b>8:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul R. Wilson</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>111 Ashfield St. Piedmont W. Va. 4-24-57</b>			
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. S. Boral</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4-25-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Jean C. Kelly</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		ATTORNEY		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE AT DEATH	
APR 4 1968		MEMPHIS, TENN.		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 5 1968		APR 5 1968		APR 5 1968		APR 5 1968	

BUREAU V. 3

APR 29 1957

RECEIVED

1. Cause of death must be stated in full, including the immediate cause, the underlying cause, and any other significant conditions contributing to death. 2. The manner of death must be stated as natural, accidental, suicide, homicide, or undetermined. 3. The date of death must be stated in full, including the day, month, and year. 4. The place of death must be stated in full, including the city, county, and state. 5. The hours of death must be stated in full, including the hour and minute. 6. The temperature at death must be stated in full, including the degree and the unit of measurement. 7. The signature of the physician must be written in full, including the name and the title. 8. The signature of the registrar must be written in full, including the name and the title. 9. The signature of the witness must be written in full, including the name and the title. 10. The signature of the deceased must be written in full, including the name and the title.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3601

CERTIFICATE OF DEATH

Reg. Dist. No.

03597

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Lonaconing</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Trost</b> Last <b>Trost</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1898</b>		9. AGE (In years last birthday) <b>58</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carver Hall</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August H. Trost</b>				14. MOTHER'S MAIDEN NAME <b>Dora Finkeldey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-16-9896</b>		17. INFORMANT <b>Werner C. Trost</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Dec 1955</b> , to <b>April 1957</b> , that I last saw the deceased alive on <b>April 12, 1957</b> , and that death occurred at <b>5:41 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Main St. Lonaconing Md.</b>			
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR. M.D.</b>				DATE SIGNED <b>4.14.57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/15/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Janette M Pool</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES E. TROST		Male		47	
DATE OF DEATH		PLACE OF DEATH		CITY	
April 1, 1957		Home		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
Heart Failure		Natural		St. James Cemetery	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
August 1, 1910		Baltimore, Md.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY	
April 1, 1957		Home		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
Heart Failure		Natural		St. James Cemetery	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
August 1, 1910		Baltimore, Md.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY	
April 1, 1957		Home		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
Heart Failure		Natural		St. James Cemetery	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
August 1, 1910		Baltimore, Md.		U.S.A.	

RECEIVED  
APR 18 1957  
BUREAU # 8

DR. MURRAY

3567

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. STREET ADDRESS <b>1202 PIEDMONT AVENUE</b>			
3. NAME OF DECEASED (Type or print) <b>George Chester VALENTINE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 4, 1900</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FURNITURE REPAIRMAN &amp; UPHOLSTERER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MD.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>ABRAHAM VALENTINE</b>			
14. MOTHER'S MAIDEN NAME <b>REBECCA ROMIG</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>214-32-2895</b>				17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Heart disease</b> (c) <b>Diabetes</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>several months</b> <b>several years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4301</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cum</b>				20g. (County) <b>MD.</b>		20h. (State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>1950</b> to <b>April 7</b> , 1957, that I last saw the deceased alive on <b>April 6</b> , 1957, and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. A. G. Murray</b>				DATE SIGNED <b>4/8/57</b>			
PHYSICIAN'S NAME (Type) <b>DR. F. A. G. MURRAY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 11, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Hantz, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER	
[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		NAME OF DECEASED		NAME OF WITNESS	
[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	

**RECEIVED**  
APR 12 1957  
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3568 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7 hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Old Town</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Loy</b> Middle <b>James</b> Last <b>Wagner</b>			4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 57</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8-1944</b>		9. AGE (In years last birthday) <b>13</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Bruce C. Wagner</b>			14. MOTHER'S MAIDEN NAME <b>Dorothy Nethers</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>(father) Bruce C. Wagner</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-abdominal hemorrhage</b> 823X DUE TO <b>Fractured pelvis &amp; bronchial hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>congestion of lungs, also fracture left femur</b> INTERVAL BETWEEN ONSET AND DEATH <b>7.2 hrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver lost control of car &amp; hit a tree in W. Va.</b>			
20c. TIME OF INJURY Month, Day, Year <b>April 27, 57</b> Hour <b>9:15</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway, near Green Spring</b>	20f. (City or town) <b>W. Va.</b>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 28-1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 30, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oldtown, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>		ADDRESS <b>Hafer</b>		24a. REC'D BY REGISTRAR <b>April 29, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W.L. Frank M.D.</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 30 1957  
BUREAU V. S.



3602

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Luke</b>				c. LENGTH OF STAY IN 1b <b>8 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>125 Cromwell</b>				e. STREET ADDRESS <b>125 Cromwell</b>			
3. NAME OF DECEASED (Type or print) First <b>Wright</b> Middle <b>Montgomery</b> Last <b>Welton</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 31, 1895</b>	
9. AGE (In years last birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min. <b>61</b>		IF UNDER 24 HRS. Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min. <b>61</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sanford Welton</b>				14. MOTHER'S MAIDEN NAME <b>Daisy Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. 1</b>				16. SOCIAL SECURITY NO. <b>109-01-4647</b>			
17. INFORMANT <b>Mrs. Harriette Welton-Luke, Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> (c) <b>Arterio-sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b> <b>7 Years</b> <b>7 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Apr. 4, 1957</b> , to <b>Apr. 5, 1957</b> , that I last saw the deceased alive on <b>Apr. 4, 1957</b> , and that death occurred at <b>5:55 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul R. Wilson</b>				ADDRESS (Street, city or town, state) <b>Piedmont, W. Va.</b>			
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>				DATE SIGNED <b>Apr. 6, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boul</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4-8-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Jean C Kelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BETHESDA, MD 20814

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		SEX	
35		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		RESIDENCE	
Actor		1125 17th Avenue N.E., Washington, D.C. 20002	
CAUSE OF DEATH		MANNER OF DEATH	
Suicide by gunshot wound		Suicide	
IMMEDIATE CAUSE		FUNDAMENTAL CAUSE	
Gunshot wound of the chest		Mental illness	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. S.

APR 9 1968

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3569

CERTIFICATE OF DEATH

03601

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Route #2 Baltimore Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WHITE</u> Last <u>WHITE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/79</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>045-16-6683</u>		17. INFORMANT <u>Rt. Address, Baltimore Pike Mrs. Dorothy M. White, Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Apr 14, 1957</u> to <u>Apr 17, 1957</u> , that I last saw the deceased alive on <u>Apr 16, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>4/18/57</u>							
ACTUAL SIGNATURE <u>R. W. Trevaskis, Sr.</u> M.D. <u>Cumberland, Md.</u>				PHYSICIAN'S NAME (Type) <u>R. W. Trevaskis, Sr. M.D. 220 Baltimore Avenue, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>April 19, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 24 1957

BUREAU V. S.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3579

## CERTIFICATE OF DEATH

Reg. Dist. No.

03692

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>W.</b> Last <b>WIEBEL</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 4, 1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED STATE POLICE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Vehicle office</b>		11. BIRTH PLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN WIEBEL</b>			
14. MOTHER'S MAIDEN NAME <b>ELIZABETH SCHNEIDER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>39 Hours</b> <b>39 Hours</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Atherosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour "a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>4/11/57</b> , 19 <b>57</b> , to <b>4/12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/12</b> , 19 <b>57</b> , and that death occurred at <b>8:27 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S.G. WEISMAN, MD.</b>				ADDRESS (Street, city or town, state) <b>54 Greene St. Cumberland Md.</b>			
DATE SIGNED <b>4/15/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Apr. 15, 1957</b>		<b>Rose Hill Cem.</b>		<b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Steinberg</b>				ADDRESS <b>Cumb. Md.</b>		24a. REC'D BY REGISTRAR <b>April 15, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. L. Frank, M.D.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED ELIZABETH SCHNEIDER		SEX F		AGE 71		DATE OF BIRTH JAN 1 1896		PLACE OF BIRTH BALTIMORE, MARYLAND	
MARRIAGE MARRIED		MARRIAGE MARRIED		MARRIAGE MARRIED		MARRIAGE MARRIED		MARRIAGE MARRIED	
OCCUPATION HOUSEWIFE		OCCUPATION HOUSEWIFE		OCCUPATION HOUSEWIFE		OCCUPATION HOUSEWIFE		OCCUPATION HOUSEWIFE	
EDUCATION HIGH SCHOOL		EDUCATION HIGH SCHOOL		EDUCATION HIGH SCHOOL		EDUCATION HIGH SCHOOL		EDUCATION HIGH SCHOOL	
RELIGION METHODIST		RELIGION METHODIST		RELIGION METHODIST		RELIGION METHODIST		RELIGION METHODIST	
PLACE OF DEATH HOSPITAL		PLACE OF DEATH HOSPITAL		PLACE OF DEATH HOSPITAL		PLACE OF DEATH HOSPITAL		PLACE OF DEATH HOSPITAL	
DATE OF DEATH APR 17 1967		DATE OF DEATH APR 17 1967		DATE OF DEATH APR 17 1967		DATE OF DEATH APR 17 1967		DATE OF DEATH APR 17 1967	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF PHYSICIAN J. H. SMITH	
SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH	

BUREAU V. S.

APR 17 1967

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

3584

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>91 Broadway</b>				d. STREET ADDRESS <b>91 Broadway</b>			
3. NAME OF DECEASED (Type or print) First <b>LOUISA</b> Middle <b>A.</b> Last <b>WILLIAMS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 14, 1864</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Hansel</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Troutman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>none</b>				17. INFORMANT Address <b>Mrs. Louis Sluss, Frostburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Semility</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Seven years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 24, 1937</b> , to <b>April 20, 1937</b> , that I last saw the deceased alive on <b>Mar 30</b> , 19 <b>37</b> , and that death occurred at <b>8:00 A.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W O M Lane</b> M.D.				ADDRESS (Street, city or town, state) <b>Frostburg</b>			
PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>				DATE SIGNED <b>Apr 22 1937</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>				ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4-22-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Nancy N. Rose</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 5

APR 29 1957

RECEIVED

1. NAME OF DECEASED <b>John P. [illegible]</b>		2. SEX <b>Male</b>		3. AGE <b>71</b>	
4. DATE OF DEATH <b>April 28, 1957</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>Home</b>	
7. CAUSE OF DEATH <b>Heart Disease</b>		8. MANNER OF DEATH <b>Natural</b>		9. SIGNATURE OF PHYSICIAN <b>[illegible]</b>	
10. SIGNATURE OF REGISTRAR <b>[illegible]</b>		11. SIGNATURE OF WITNESS <b>[illegible]</b>		12. SIGNATURE OF DECEASED <b>[illegible]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03604

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sylvan Retreat</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Mt. Savage</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Willison</b> Last <b>Willison</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25-18783</b>
9. AGE (In years last birthday) <b>7 8 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>8</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired laborer-Cumberland Incinerator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gilpin, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isiah Willison</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Robinette</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Sylvan Retreat records</b>	
17. INFORMANT <b>Sylvan Retreat records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> about <b>7 yrs</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 13-1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 15, '57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Flintstone, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>April 15, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>H.R. Trautz, M.D.</b>	

Hafer

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 17 1957  
BUREAU V. S.



## CERTIFICATE OF DEATH

Reg. Dist. No. 4

3572

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>17 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>231 HOPEWELL AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>VIRGINIA</b> Middle <b>Susan</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 25, 1908</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA. Wardensville</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William LANDACRE</b>				14. MOTHER'S MAIDEN NAME <b>MAE V. Rummer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Luther W. Wilson</b> Address <b>231 Hopewell Ave., Aliquippa, Penna.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Stenosis</b> <b>410x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3/27</b> , 19 <b>57</b> , to <b>4/13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/13</b> , 19 <b>57</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b>				ADDRESS (Street, city or town, state) <b>476 N. Centre St</b> DATE SIGNED <b>4/14/57</b>			
NAME (Type) <b>LEO H. LEY JR.</b>				Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wardensville Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Wardensville, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>April 16, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. L. Grantz, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION	
JAMES J. WILSON		45		M		W		MARRIED		LABORER	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
100 WILSON ST. BOSTON		APR 10 1935		HOME		HEART DISEASE		NATURAL		100	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		SIGNED BY		REGISTERED	
APR 15 1890		MASSACHUSETTS		HIGH SCHOOL		CATHOLIC		J. J. WILSON		J. J. WILSON	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
JAMES J. WILSON		MARY J. WILSON		LABORER		HOUSEWIFE		100 WILSON ST. BOSTON		100 WILSON ST. BOSTON	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S RELIGION		MOTHER'S RELIGION	
APR 15 1860		APR 15 1865		MASSACHUSETTS		MASSACHUSETTS		CATHOLIC		CATHOLIC	
FATHER'S DECEASED		MOTHER'S DECEASED		FATHER'S DECEASED		MOTHER'S DECEASED		FATHER'S DECEASED		MOTHER'S DECEASED	
NO		NO		NO		NO		NO		NO	
FATHER'S DECEASED		MOTHER'S DECEASED		FATHER'S DECEASED		MOTHER'S DECEASED		FATHER'S DECEASED		MOTHER'S DECEASED	
NO		NO		NO		NO		NO		NO	

BUREAU V. S.

APR 10 1935

RECEIVED

3695

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>P a.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>23 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wellersburg 75x-3</u> ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Celanese dispensory</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Charles</u> Last <u>Wingert</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1916</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spinner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Wellersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Wingert</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2 214-07-3195</u>		17. INFORMANT Address <u>Cumberland, Md.</u> <u>(sister) Ada King, Mt. Savage Road,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (c) <u>  </u> DUE TO (a), stating the underlying cause lost. <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 9-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wellersburg Lutheran Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wellersburg, Pennsylvania.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler, Hyndman, Pennsylvania.</u>				24a. REC'D BY REGISTRAR <u>April 10, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Grantz M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause of the delay in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BULLETIN 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. S.

APR 11 1957

RECEIVED